

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 05/28/2014
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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 Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 04/04/14 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/28/14</p> <p>Facility Number: 000388 Provider Number: 155807 AIM Number: 100454140</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this PSR 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</p>	K010000	<p>This plan of correction 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 or other services in the facility. Nor does this submission constitute and 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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K010025 SS=E	<p>corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 50 and had a census of 42 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 06/02/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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</p>			

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	<p>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 Maintenance Supervisor during a tour of the facility at 11:00 a.m. on 05/28/14, 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. Each of the five holes were sealed with expandable foam which is not an approved material for maintaining the fire resistance of a smoke barrier. Based</p>	K010025	<p>It is the policy of Rural Health Care to attain and maintain compliance of K025. I. The facility will remove expandable foam form all smoke barrier penetrations. All penetrations through smoke barriers will be sealed by approved fire rate intumescent caulk. II. The deficient practice has the potential to affect 20 residents, staff and family members. An audit was facility audit was conducted and to identify any other potential residents, staff or family members that could be affected with none noted. III. The facility will monitor smoke barriers and when penetration occur in the future will seal the penetration with approved fire rated intumescent caulk. IV. The Administrator or his designee will conduct rounds to ensure that the smoke barriers remain intact.</p>	06/25/2014

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K010046 SS=C	<p>on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned openings filled with expandable foam failed to maintain the fire resistance of the ceiling smoke barrier.</p> <p>This deficiency was cited on 04/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p> <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. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be</p>	K010046	It is the practice of Rural Health Care attain and maintain compliance of K046. 1. The facility will test the battery operated emergency lights monthly for not less than 30 seconds and annually for not less than 90 minutes. The facility will	06/25/2014			

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	<p>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 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 Maintenance Supervisor from 10:50 a.m. to 11:00 a.m. on 05/28/14, documentation of functional testing for at least 30 seconds for six of six battery operated emergency lights was not available for review for April 2014. In addition, documentation of an annual test for all six battery powered emergency lights for at least a 1 ½ hour duration was not available for review. Although the facility's plan of correction (POC) indicated annual testing and monthly functional testing would be done by May 2, 2014, testing documentation was not available up to the date of this visit. Based on observations with the Maintenance Supervisor during a tour of the facility from 11:00 a.m. to 11:40 a.m.</p>		<p>maintain and provide documentation that shows each battery operated light has been subjected to monthly and annual testing. II. The deficient practice could affect all residents and guest in the facility. III. The facility will maintain and provide documentation that shows each battery operated light has been subjected to monthly and annual testing. IV. The Administrator or his designee will review the battery operated emergency lighting testing to ensure the record is being maintained.</p>	

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K010064 SS=D	<p>on 05/28/14, a total of six battery operated emergency lights were located in the facility. Based on interview at the time of record review and of the observations, the Maintenance Supervisor acknowledged six battery operated emergency lights were located in the facility, documentation of monthly functional testing for not less than 30 seconds for April 2014 and documentation of an annual ninety minute test for each battery operated emergency light were each not available for review.</p> <p>This deficiency was cited on 04/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all</p>			

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	<p>health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>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> <p>Based on observation with the Maintenance Supervisor during a tour of the facility at 11:05 a.m. on 05/28/14, 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 April 2014.</p>	K010064	<p>It is the practice of Rural Health Care to attain and maintain compliance of K064. I. The facility will conduct monthly inspections of the fire extinguishers with the date of inspection and initials of the person performing the inspection being recorded. II. The deficient practice has the potential to affect 3 staff members and visitors in the vicinity of the Maintenance office of the maintenance office. III. The Maintenance Supervisor mark on his facility floor plan where each fire extinguisher is located to ensure that each extinguisher gets inspected monthly. IV. The Administrator or his designee will conduct random checks to ensure that the fire extinguishers have been inspected.</p>	06/25/2014

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K010072 SS=E	<p>Although the facility's plan of correction (POC) indicated monthly inspections would be done by May 2, 2014, monthly inspections had not been documented up to the date of this visit. Based on interview at the time of observation, the Maintenance Supervisor 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 April 2014.</p> <p>This deficiency was cited on 04/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>				

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	<p>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.</p> <p>7.1.10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 means of egress was 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 needing to exit the facility by the northeast and southeast exits.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility at 11:10 a.m. on 05/28/14, a three foot high by two feet wide by two feet deep wooden paper shredder was stored in the corridor by the Nurses Station. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the corridor by the Nurses Station was not maintained free of all obstructions to instant use.</p> <p>This deficiency was cited on 04/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>	K010072	<p>It is the practice of Rural Health care to attain and maintain compliance of K072. The facility will remove the paper shredder from the corridor near the nurse's station. II. The deficient practice has the potential to affect 30 residents, staff members and visitors. III. The Maintenance Supervisor will conduct ddaily rounds toensure that the facility's egresses remain free of obstructions. IV. The Administrator or his designee will conduct rounds to ensure that the the facility's egresses remain free of obstructions.</p>	06/25/2014

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K010144 SS=F	<p>3.1-19(b)</p> <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 1 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>	K010144	<p>It is the policy of Rural Health Care to attain and maintain compliance of K0144. The facility will conduct monthly load tests for the emergency generator in accordance with NFPA 110, 6-4.2. The facility will conduct weekly tests for the emergency generator in accordance with NFPA 110, 6-3.6. II. The deficient practice has the potential to affect all residents , staff members and visitors of the facility. III. The facility will maintain proper documentation verifying the monthly and weekly load test were conducted. IV. The Administrator or his designee will monitor the documentation to ensure the monthly and weekly generator tests were conducted and properly documented.</p>	06/25/2014
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	<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, 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 Maintenance Supervisor during record review from 10:50 a.m. to 11:00 a.m. on 05/28/14, documentation of monthly load testing for April 2014 was not available for review. Although the facility's plan of correction (POC) indicated monthly load testing would be documented by May 2, 2014, load testing documentation up to the date of this visit was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged documentation</p>			

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	<p>of monthly load testing for April 2014 was not available for review.</p> <p>This deficiency was cited on 04/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</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 7 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical 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</p>			

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	<p>and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator Preventive Maintenance" documentation with the Maintenance Supervisor during record review from 10:50 a.m. to 11:00 a.m. on 05/28/14, documentation of weekly inspections of the starting batteries for the emergency generator for the seven week period of 04/04/14 through 05/23/14 was not available for review. Although the facility's plan of correction (POC) indicated weekly inspections would be documented by May 2, 2014, weekly inspection documentation up to the date of this visit was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged documentation of weekly inspections of the starting batteries for the emergency generator for the seven week period of 04/04/14 through 05/23/14 was not available for review.</p> <p>This deficiency was cited on 04/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>			

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

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