

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155527	X(2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		X(3) DATE SURVEY COMPLETED  03/29/2011
NAME OF PROVIDER OR SUPPLIER  PINEKNOLL REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 160 NORTH MIDDLE SCHOOL ROAD WINCHESTER, IN47394		
(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	
K0000	<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: 03/29/11</p> <p>Facility Number: 000532 Provider Number: 155527 AIM Number: 100267180</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Pineknoll Rehabilitation Centre was found in substantial 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 (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and single station smoke detection in all resident sleeping rooms. The facility has a capacity of 58 and had a census of 54 at</p>	K0000			

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>the time of this visit.</p> <p>Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 04/05/11.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0130 SS=C	<p>Based on record review and interview, the facility failed to ensure 4 of 4 water heaters had a current inspection certificate to ensure the water heater was in safe operating condition. 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 residents. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 03/29/11 at 10:30 a.m., the two gas fueled water heaters in the Service Hall mechanical room, the one gas fueled water heater in the West Hall mechanical room, and the one gas fueled water heater in the East Hall mechanical room had a two year Certificate of Inspection with an expiration date of 03/11/2011. This was verified by the maintenance supervisor at the time of record review.</p> <p>3.1-19(b)</p>	K0130	<p>Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. 1 &amp; 2. No residents were affected but all of the potential to be affected. The facility called ISDH on 3/29/11 and completed a service call request for the water heaters. A fax was received from ISDH indicating the call had been made for the inspection of the water heaters but no date was given as to when this would occur. (See Attachment A)3. The maintenance director has been re-educated on water heater inspection time frames. An inspection form has been implemented. (See Attachment B)4. The maintenance director or designee will be responsible for completing the inspection form on a monthly basis to ensure inspections are completed timely. The results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.5. The</p>	03/30/2011	

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

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FORM APPROVED

OMB NO. 0938-0391

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			above corrective actions will be completed on or before March 30, 2011		