

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155374 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 02/25/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553 |
|--|---|

| (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: 02/25/13</p> <p>Facility Number: 000571 Provider Number: 155374 AIM Number: 100266920</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Martin County Healthcare & Rehabilitation Center 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and in all resident sleeping</p> | K0000 | <p>K000</p> <p>By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that this plan of corrections be considered our allegation of compliance effective 3/9/2013 to the findings of the Life Safety Code Recertification Survey conducted 2/25/2013 at our facility.</p> | |

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.

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155374 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 02/25/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOGOOTE, IN 47553 |
|--|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
| | <p>rooms. The facility has a capacity of 62 and had a census of 30 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except one detached shed used as an employee only smoke shack.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/27/13.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following:</p> | | | |

| | | | | | | | |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155374 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/25/2013 | |
| NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553 | | | |
| (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 | | | |
| K0050 SS=C | <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 ensure fire drills were held at varied times for 3 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Life Safety book on 02/25/13 at 9:15 a.m. with the Maintenance Supervisor present, four of four second shift (evening) fire drills were performed between 2:45 p.m. and 3:30 p.m. During an interview at the time of record review, the Maintenance Supervisor acknowledged the times the second shift fire drills were performed.</p> <p>3-1.19(b)</p> | K0050 | <p>K050</p> <p>It is the intent of this facility to conduct fire alarms as per regulation at least quarterly on each shift. These drills should take place at varied times to familiarize the staff with procedures as part of an established routine. All residents have the potential to be affected.</p> <p>The corrective action taken for residents at risk for being affected by the deficient practice is that fire drills will be conducted at varied times one each shift at least quarterly to familiarize the staff with procedures as part of an established routine.</p> <p>Additional measures or systemic changes that have been put into place to ensure that the deficient practice does not recur is that a Q.A. monitoring tool has been developed and implemented to monitor variance in fire drill times. This tool will be completed and monitored by the Administrator or designee</p> | 03/09/2013 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155374 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 02/25/2013 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOGOOTE, IN 47553 |
|--|---|

| (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 |
|--------------------|--|---------------|--|----------------------|
| | | | monthly x 6 months with results taken to Q.A. to assess for the need for further intervention(s). Completion Date: 3/9/2013 | |