STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 07/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-BREMEN	316 WOODIES LN BREMEN, IN 46506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	A Life Safety Code Recertification and State Licensure Survey and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/31/12 Facility Number: 000506 Provider Number: 155474 AIM Number: 100266530 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code and Quality Assurance Walk-thru survey, Bremen 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.	K0000	The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, and resident rooms 301-309. Battery powered smoke detectors were located in resident rooms 101-124. No smoke detectors were provided in resident rooms 201-216. The facility has the capacity for 97 and had a census of 94 at the time of this survey. The facility was found not in compliance with state law in regard to smoke detector coverage. The facility was fount in compliance with state law in regard to sprinkler coverage. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 08/02/12.			

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	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 1. Based on observation and interview, the facility failed to provide a wet location in 1 of 7 smoke compartments with a GFCI (ground fault circuit interrupter) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice visitors, staff and 30 residents on the south wing. Findings include: Based on observation with the	K0147	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*: No residents affected by the deficient practice. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*: No residents affected by the deficient practice. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: The maintenance director replaced the electrical outlet in the south nourishment room with a GFCI outlet. The flexible cord was removed and an outlet was installed so the refrigerator could be plugged into the new outlet.	08/17/2012

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	maintenance director and administrator on 07/31/12 at 4:14 p.m., the electrical outlet in south nourishment room was located 24 inches from the sink. The outlet was not provided with GFCI to prevent electric shock. The maintenance director said at the time of observation, the outlet was not protected by a GFCI circuit in the electrical panel. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring in 1 of 7 smoke compartments. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect visitors, staff, and 30 residents in the south wing. Findings include: Based on observation with the maintenance director and		*To ensure the deficient practice does not recur, the monitoring system established is*: The Executive Director and Maintenance Director performed a facility audit for any other outlets that need changed to GFCI and any flexible cords being used. This was the only outlet that needed changed and flexible cord being used so there is no further action or monitoring for this deficient practice.	

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	administrator on 07/31/12 at 4:00 p.m., an extension cord was used to supply power to a refrigerator in the south medicine room. The maintenance director said at the time of observations, he was unaware the extension cord was in use. 3.1-(19)b			

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K9999	State Findings 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following: (1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012. (2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012. (3) Have a battery operated or hard-wired smoke detector in each resident ' s room before July 1, 2012. This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to install smoke detectors in each	K9999	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*: No residents affected by the deficient practice. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*: No residents affected by the deficient practice. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: The facility was in the process of installing the battery operated smoke detectors. Half of the facility was already done before the visit from ISDH surveyor. Rooms 201 through 216 were completed the next day which was August 1, 2012. *To ensure the deficient practice does not recur, the monitoring system established is*:	08/17/2012

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	resident's room before July 1, 2012. This deficient practice could affect 30 residents in the facility. Findings include: Based on observation with the maintenance director and administrator on 07/31/12 between 1:00 p.m. and 4:00 p.m., smoke detectors were not provided in resident rooms 201-216. The maintenance director said at the time of observation, he was in the process of installing battery powered smoke detectors in all resident rooms. 3.1-19(ff)		All resident rooms in the facility have smoke detectors so there is no further action or monitoring for this deficient practice.	