

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155699	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/06/2013
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NAME OF PROVIDER OR SUPPLIER  BRIDGEWATER REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 715 N MILL ST HARTFORD CITY, IN 47348
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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: 02/06/13</p> <p>Facility Number: 000290 Provider Number: 155699 AIM Number: 100379970</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Bridgewater Rehabilitation Centre 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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridors and hard wired smoke detectors in 15 resident</p>	K0000	<p>Submission of this plan of correction shall not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirements under state and federal laws. Please accept this plan of correction as our credible allegation of compliance.</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.

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	<p>rooms. Battery operated smoke detectors are installed in the remaining 25 resident rooms. The facility has a capacity of 78 and had a census of 48 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/12/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0025 SS=D	<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 maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect possibly 3 residents in the Beauty Shop and 200 hall treatment room.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Supervisor on 02/06/13 from 12:47 p.m. to 1:25 p.m., there is a one half inch gap alongside the sprinkler head in the 200 hall nurses' station treatment room, a one fourth inch gap alongside the sprinkler drain in the Beauty Shop and two penetrations in the main hall mechanical room which were sealed with expandable foam. This was acknowledged by the</p>	K0025	<p>1. No residents were negatively affected. The gaps alongside the sprinkler heads were repaired on 2-11-2013. The expandable foam was removed from the 200 hall mechanical room and replaced with fire barrier caulk on 2-11-2013.</p> <p>2. No residents were negatively affected by the deficient practice with 3 residents having the potential to be affected. The gaps alongside the sprinkler heads were repaired on 2-11-2013. The expandable foam was removed from the 200 hall mechanical room and replaced with fire barrier caulk on 2-11-2013.</p> <p>3. The maintenance Director was inserviced on 2-10-2013 regarding the gaps around</p>	02/11/2013			

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	Maintenance Supervisor at the time of observations.  3.1-19(b)		<p><b>sprinkler heads and the replacement of the expandable foam in the maintenance room on 200 hall with fire barrier caulking. The maintenance Director or designee will complete weekly preventative maintenance rounds to ensure the deficient practice does not recur.</b></p> <p><b>4. Weekly preventative maintenance rounds will be reviewed at monthly QA meeting with the plan adjusted accordingly for continued compliance.</b></p> <p><b>5. Completed 2-11-2013</b></p>		

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K0038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 6 of 7 exit doors were accessible. Health care occupancies permit delayed egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(c) requires an irreversible process shall release the lock within 15 seconds upon application of a force to the release device. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS." This deficient practice could affect three of four smoke compartments.</p> <p>Findings include:</p> <p>1. Based on observations with the Administrator and the Maintenance Supervisor on 02/06/13 from 12:52 p.m. to 2:23 p.m., all exit doors, except the 100 hall north exit, were equipped with electromagnetic locks and all but the 100 hall west exit door released after pushing the door for 15 seconds, but they lacked</p>	K0038	<p>1. No residents were negatively affected. The 100 hall door was repaired on 2-11-2013. All exit doors received the proper signage on 2-11-2013.</p> <p>2. No residents were negatively affected with all having the potential to be affected. The 100 hall door was repaired on 2-11-2013. All exit doors received the proper signage on 2-11-2013.</p> <p>3. The maintenance director was inserviced on 2-10-2013 regarding the proper signage on the doors, and the requirement regarding the doors equipped with electromagnetic locks releases after applying force for 15 seconds. The maintenance director or designee will complete weekly preventative maintenance rounds to ensure the doors have proper signage and release after applying force for 15 seconds.</p> <p>4. The weekly preventative maintenance rounds will be reviewed at the monthly QA meeting with the plan adjusted</p>	02/11/2013			

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	<p>the proper signage. This was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>2. Based on observation with the Administrator and the Maintenance Supervisor on 02/06/13 at 2:23 p.m., the 100 hall west exit door, which was equipped with an electromagnetic lock, would not release after applying force to the release device for 15 seconds. The Administrator acknowledged the 100 hall west exit door did not release within 15 seconds of applying force to the releasing device.</p> <p>3.1-19(b)</p>		<p><b>accordingly for continued compliance.</b></p> <p><b>5. Completed 2-11-2013</b></p>		

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K0048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire plan to 3 of 4 strategic locations throughout the facility. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a record review with the Administrator and the Maintenance Supervisor on 02/06/13 at 12:08 p.m., the "Fire Disaster Plan" at both nurses' stations and in the maintenance office did not address the following:</p> <ol style="list-style-type: none"> <li>a. the types of fire extinguishers throughout the facility including the</li> </ol>	K0048	<ol style="list-style-type: none"> <li>1. No residents were negatively affected. All disaster manuals have been updated with correct information which includes a complete written fire plan.</li> <li>2. No residents were negatively affected with all having the potential to be affected. All disaster manuals have been updated with correct information which includes a complete written fire plan.</li> <li>3. The maintenance director was inserviced on 2-10-2013 regarding the disaster manuals. The maintenance director or designee will be responsible to check the disaster manuals weekly to ensure the information is kept current and up to date and documented on rounds sheet.</li> <li>4. Weekly checks will be reviewed at the monthly QA meeting with the plan adjusted accordingly for continued c</li> <li>5. Completed 2-11-2013</li> </ol>	02/11/2013			

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	<p>kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system.</p> <p>b. the proper staff response to an alarm from a battery operated smoke detector</p> <p>c. stated how the staff "should" respond to an emergency situation not how they are required to respond.</p> <p>This was confirmed by the Administrator at the time of record review.</p> <p>3.1-19(b)</p>			

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K0051 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 5 of 5 manual fire alarm boxes were mounted at the proper height. NFPA 72, The National Fire Alarm Code, 2-8.1 states the operable part of each manual fire alarm box shall be not less the forty two inches and not more than fifty four inches from the floor level. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Supervisor on 02/06/13 from 1:05 p.m. to</p>	K0051	<p>1. No residents were negatively affected. All manual pull stations will be lowered to 48" by Elwood Fire Equipment Company by 3-6-2013.</p> <p>2. No residents were negatively affected with all having the potential to be affected. All manual pull stations will be lowered to 48" by Elwood Fire Equipment Company by 3-6-2013.</p> <p>3. The maintenance director was inserviced on 2-10-2013 regarding the proper height of manual pull stations in nursing</p>	03/06/2013

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	2:19 p.m., all five manual fire alarm boxes measured sixty inches from the floor level. Measurements were provided by the Maintenance Supervisor at the time of observations.  3.1-19(b)		homes. The maintenance Director has contacted Elwood Fire Equipment Company and all of the manual pull stations will be lowered to 48" by 3-6-2013  4. The maintenance director will check the height of the manual pull stations monthly to ensure they remain at proper height.  5. Completed 3-06-2013		

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K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 4 building overhangs in accordance with NFPA 13, Standard for Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13-1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect at least 9 residents on the 100 hall.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator and the Maintenance Supervisor on 02/06/13 at 2:18 p.m., there was an unsprinklered combustibile</p>	K0056	<p>1. No residents were negatively affected. Installation of an automatic sprinkler system has been scheduled by Elwood Fire Equipment Company by 3-06-2013.</p> <p>2. No residents were negatively affected with all having the potential to be affected. Installation of an automatic sprinkler system has been scheduled by Elwood Fire Equipment Company by 3-06-2013.</p> <p>3. The maintenance director was inserviced on 2-10-2013 regarding the requirement of a sprinkler for all overhangs measuring 4 feet or greater. Elwood Fire Equipment Company will install an</p>	03/06/2013			

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	<p>overhang measuring four foot four inches from the building at the 100 hall west exit. Measurements were provided by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p><b>automatic sprinkler system by 3-06-2013.</b></p> <p><b>4. The maintenance director will check all overhangs on a monthly basis during preventative maintenance rounds to ensure all overhangs remain sprinkled as required.</b></p> <p><b>5. Completed 3-06-2013</b></p>	

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K0066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 self closing metal trash cans in a smoking area was used to empty ashtrays only. This deficient practice could affect at least 20 residents evacuated through the main dining room exit in the event of an emergency.</p> <p>Findings include:  Based on an observation with the Administrator and the Maintenance Supervisor on 02/06/13 at 11:35 a.m., the</p>	K0066	<p>1. No residents were negatively affected. The cigarette butts were removed from the mulched area at the main entrance of the facility. The trash was removed from the metal cigarette can located in the resident and employee smoking area.</p> <p>2. No residents were negatively affected with all having the potential to be affected. The cigarette butts were removed from the</p>	02/11/2013			

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	<p>metal trash can in a smoking area contained a mixture of cigarettes butts and combustible trash. This was acknowledged by the Administrator and the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 areas where smoking was permitted for staff and residents was maintained and the metal container with a self closing cover was used for an ashtray. This deficient practice could affect any residents, staff and visitors entering the building through the main entrance.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator and the Maintenance Supervisor on 02/06/13 at 2:30 p.m., there were at least sixteen cigarette butts in the mulch near the main entrance. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p><b>mulched area at the main entrance of the facility. The trash was removed from the metal cigarette can located in the resident and employee smoking area.</b></p> <p><b>3. The maintenance director was inserviced on 2-10-2013 regarding the fact that no cigarette butts can be in the mulched area at the entrance of the building, and that the metal can located at the resident and employee smoking area cannot contain any trash at all. The maintenance director or designee will complete daily rounds in the morning and afternoon on working days to ensure the deficient practice does not recur.</b></p> <p><b>4. The daily preventative maintenance rounds will be reviewed at the monthly QA meeting with the plan adjusted accordingly for continued compliance.</b></p> <p><b>5. Completed 2-11-2013</b></p>		

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(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			
K0067 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure an undetermined number of dampers in the ventilation system were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 02/06/13 at 11:50 a.m., the access panel in both of the furnaces in the service hall mechanical room were opened revealing dampers at the ceiling in</p>	K0067	<p>1. No residents were negatively affected. The dampers are scheduled to be inspected by Elwood Fire Equipment Company by 3-06-2013.</p> <p>2. No residents were negatively affected with all having the potential to be affected. The dampers are scheduled to be inspected by Elwood Fire Equipment Company by 3-06-2013.</p> <p>3. The maintenance director was inserviced on 2-10-2013 regarding the regulations pertaining to damper inspections. The dampers are scheduled to be inspected by Elwood Fire Equipment company by 3-06-2013.</p> <p>4. The preventative maintenance rounds will be reviewed at the monthly QA meeting with the plan adjusted accordingly for continued compliance.</p> <p>5. Completed 3-06-2013</p>	03/06/2013			

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	<p>the ductwork. Based on an interview with the Maintenance Supervisor at the time of observation, he acknowledged the furnaces had dampers but he was unable to confirm if the dampers were fire/smoke dampers or dampers used to control the flow of air through the ducts.</p> <p>3.1-19(b)</p>			

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K0075 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area for 1 of 43 resident rooms. This deficient practice could affect 1 resident on the 100 hall.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 02/06/13 at 2:00 p.m., two forty four gallon soiled linen and trash containers were unattended and stored side by side in resident room 102. Based on an interview with the Administrator at the time of observation, he was not aware the facility had created a hazardous area by using containers greater than thirty two gallons in a resident room.</p> <p>3.1-19(b)</p>	K0075	<ol style="list-style-type: none"> <li><b>1. No residents were negatively affected. The containers were removed from room 102.</b></li> <li><b>2. No residents were negatively affected with 1 having the potential to be affected. The containers were removed from room 102.</b></li> <li><b>3. The maintenance director was inserviced on 2-10-2013 regarding the regulations of barrel sizes that are allowed in resident rooms. The director of maintenance will complete monthly room rounds to ensure the deficient practice does not recur.</b></li> <li><b>4. The monthly preventative maintenance rounds will be reviewed at monthly QA meeting with the plan adjusted accordingly for continued compliance.</b></li> </ol>	02/11/2013			

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			5. Completed 2-11-2013	

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K0076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 exterior oxygen supply storage locations was protected from the weather. NFPA 99, 4-3.5.2.2 requires cylinders stored in the open shall be protected against extremes of weather. During winter, cylinders stored in the open shall be protected from against an accumulation of ice or snow. In summer, cylinders stored in the open shall be screened against continuous exposure to direct rays of the sun in those localities where extreme temperatures prevail. This deficient practice could affect at least 20 residents evacuated through the main dining room exit in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 02/06/13 at 11:00 a.m.,</p>	K0076	<p>1. No residents were negatively affected. The oxygen containers are now covered to protect them from the elements. 2. All residents have the potential to be affected. The oxygen containers are now covered to protect them from the elements. 3. The maintenance director was inserviced on 2/10/13 regarding the requirement to keep oxygen tanks covered from the elements. The maintenance director will complete monthly preventative maintenance rounds to ensure the oxygen tanks remain covered as required. 4. The monthly preventative maintenance rounds will be reviewed at the monthly QA meeting with the plan adjusted accordingly for continued compliance. 5. Completion date: 2/11/13</p>	02/11/2013	

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	<p>four large liquid oxygen containers, approximately five feet tall, were located in a chain link enclosure near the service entrance and the main dining room exit. The enclosure was not protected from sun, snow, or rain. The Administrator and the Maintenance Supervisor agreed at the time of observation, the equipment was exposed to all types of weather.</p> <p>3.1-19(b)</p>			

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K0143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to provided posted signs indicating transferring is occurring in 1 of 2 oxygen transferring locations. This deficient practice could affect at least 9 residents in the 100 hall.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 02/06/13 at 2:15 p.m., the 100 hall oxygen transferring room lacked the required sign stating transferring is occurring. This was acknowledged by the Administrator at the time of observation.</p> <p>3.1-19(b)</p>	K0143	<p>1. No residents were negatively affected. A new sign has been ordered for the oxygen room. A temporary sign indicating oxygen transfer occurring has been implemented until the new sign has been delivered and installed.</p> <p>2. No residents were negatively affected with all having the potential to be affected. A new sign has been ordered for the oxygen room. A temporary sign indicating oxygen transfer occurring has been implemented until the new sign has been delivered and installed.</p>	03/06/2013	

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			<p><b>3. The maintenance director was inserviced on 2-10-2013 regarding the requirement for a sign located on the oxygen room door to show when transfilling of oxygen is occurring. The maintenance director will complete monthly preventative maintenance rounds to ensure that the sign is located on the oxygen room door and it remains functional.</b></p> <p><b>4. The monthly preventative maintenance rounds will be reviewed at monthly QA meeting with the plan adjusted accordingly for continued compliance.</b></p> <p><b>5. Completed 3-06-2013</b></p>		

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K0144 SS=C	<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 observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>(a) Individual visual signals shall indicate:</p> <ol style="list-style-type: none"> <li>1. When the emergency or auxiliary power source is operating to supply power to load.</li> <li>2. When the battery charger is malfunctioning.</li> </ol> <p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:</p> <ol style="list-style-type: none"> <li>1. Low lubricating oil pressure.</li> <li>2. Low water temperature.</li> <li>3. Excessive water temperature.</li> <li>4. Low fuel - when the main fuel storage</li> </ol>	K0144	<p>1. <b>No residents were negatively affected. The annunciator panel was repaired by Safe Care on 2-21-2013. A letter of reliability from the natural gas company has been obtained regarding the fuel supply that contains the 5 required elements.</b></p> <p>2. <b>No residents were negatively affected with all having the potential to be affected. The annunciator panel was repaired by Safe Care on 2-21-2013. A letter of reliability from the natural gas company has been obtained regarding the fuel supply that contains the 5 required elements.</b></p> <p>3. <b>The maintenance director was inserviced on 2-10-2013 regarding the annunciator panel and the need for an annual detailed letter from the natural gas company regarding the fuel supply that contains the 5 required elements. The maintenance director will complete weekly checks of the annunciator panel to ensure that it is working correctly. The</b></p>	02/21/2013			

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	<p>tank contains less than a 3-hour operating supply.</p> <p>5. Overcrank (failed to start).</p> <p>6. Overspeed.</p> <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 02/06/13 at 12:40 p.m., when the lamp test button on the emergency generator remote annunciator panel was pushed, the lamps next to the engine temperature, low battery voltage and high battery voltage did not illuminate. Additionally, the toggle switch to silence the alarm on the generator remote annunciator panel was broken. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3-1.19(b)</p>		<p><b>maintenance director will also be responsible in obtaining an annual letter from the natural gas company regarding the fuel supply that contains the 5 required elements.</b></p> <p><b>4. The weekly annunciator panel checks will be reviewed at monthly QA meeting with the plan adjusted accordingly for continued compliance.</b></p> <p><b>5. Completed 2-21-2013</b></p>				

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	<p>2. Based on interview and record review, the facility failed to ensure the off site fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110, 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <ul style="list-style-type: none"> <li>a) Liquid petroleum products at atmospheric pressure</li> <li>b) Liquefied petroleum gas (liquid or vapor withdrawal)</li> <li>c) Natural or synthetic gas</li> </ul> <p>Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source.</p> <p>CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:</p>			

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	<p>1. A statement of reasonable reliability of the natural gas delivery.</p> <p>2. A brief description that supports the statement regarding the reliability.</p> <p>3. A statement that there is a low probability of interruption of the natural gas.</p> <p>4. A brief description that supports the statement regarding the low probability of interruption,</p> <p>5. The signature of a technical person from the natural gas provider.</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview with the Administrator and the Maintenance Supervisor on 02/06/13 at 10:46 a.m., the fuel source for the emergency generator was natural gas. Additionally, based on record review, the facility did have a letter from their natural gas provider (Vectren) dated October 12, 2012 but the letter did not include all the items above required for a letter confirming the reliability of a natural gas fuel source for an emergency generator. The letter lacked supporting statements of reliability of natural gas, a brief description supporting the statement regarding the reliability, low probability of interruption of the natural gas service, a statement there is a low probability of</p>				

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	<p>interruption of the natural gas and a signature of a technical person from the natural gas provider. This was acknowledged by the Administrator at the time of record review.</p> <p>3.1-19(b)</p>			

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K0154 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to protect 48 of 48 residents by providing a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 or more hours in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned, and</p>	K0154	<p>1. No residents were negatively affected. The Fire Watch Policy and Procedure has been updated to include the missing information.</p> <p>2. No residents were negatively affected with all having the potential to be affected. The Fire Watch Policy and Procedure has been updated to include the missing information.</p> <p>3. The maintenance director was inserviced on 2-10-2013 regarding the Fire Watch Policy and Procedure and the missing information. The maintenance director will be responsible for updating the disaster manuals as needed to remain in compliance.</p> <p>4. The maintenance director will update the disaster manuals as needed and bring any needed changes to the monthly QA meeting to ensure</p>	02/11/2013			

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NAME OF PROVIDER OR SUPPLIER  BRIDGEWATER REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 715 N MILL ST HARTFORD CITY, IN 47348			
(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>lastly, 11-7 requires notification of everyone again when the system is restored. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Fire Watch Policy &amp; Procedure" documentation with the Administrator and the Maintenance Supervisor on 02/06/13 at 12:17 p.m., the facility did have a written policy and procedure for an impaired sprinkler system available for review, but it did not include the designated person(s) shall be trained in the duties or responsibilities for conducting the fire watch. Additionally, the contact phone numbers for the local fire department and the insurance company were not included. Based on an interview with the Administrator at the time of record review, he acknowledged the fire watch policy lacked documentation stating the person(s) conducting the fire watch shall be properly trained and the contact phone numbers.</p> <p>3.1-19(b)</p>		<p><b>all manuals are adjusted accordingly for continued compliance.</b></p> <p><b>5. Completed 2-11-2013</b></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155699		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  02/06/2013	
NAME OF PROVIDER OR SUPPLIER  BRIDGEWATER REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 715 N MILL ST HARTFORD CITY, IN 47348			
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K0155 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 48 of 48 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice affect all occupants.</p>	K0155	<p>1. No residents were negatively affected. The Fire Watch Policy and Procedure has been updated to include the missing information.</p> <p>2. No residents were negatively affected with all having the potential to be affected. The Fire Watch Policy and Procedure has been updated to include the missing information.</p> <p>3. The maintenance director was inserviced on 2-10-2013 regarding the Fire Watch Policy and Procedure and the missing information. The maintenance director will be responsible for updating the disaster manuals as needed to remain in compliance.</p> <p>4. The maintenance director will update the disaster manuals as needed and bring any needed changes to the monthly QA meeting to ensure all manuals are adjusted</p>	02/11/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155699	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/06/2013
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NAME OF PROVIDER OR SUPPLIER  BRIDGEWATER REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 715 N MILL ST HARTFORD CITY, IN 47348
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	<p>Findings include:</p> <p>Based on record review of the "Fire Watch Policy &amp; Procedure" documentation with the Administrator and the Maintenance Supervisor on 02/06/13 at 12:17 p.m., the facility did have a written policy and procedure for an impaired fire alarm system available for review, but it did not include the designated person(s) shall be trained in the duties or responsibilities for conducting the fire watch. Additionally, the contact phone numbers for the local fire department was not included. Based on an interview with the Administrator at the time of record review, he acknowledged the fire watch policy lacked documentation stating the person(s) conducting the fire watch shall be properly trained and the necessary contact phone numbers.</p> <p>3.1-19(b)</p>		<p><b>accordingly for continued compliance.</b></p> <p><b>5. Completed 2-11-2013</b></p>	