

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155486	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 10/28/2013
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NAME OF PROVIDER OR SUPPLIER MIDDLETOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 131 S 10TH ST MIDDLETOWN, IN 47356
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K020000	<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: 10/28/13</p> <p>Facility Number: 000343 Provider Number: 155486 AIM Number: 100289600</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Middletown Nursing and Rehabilitation 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 facility consisted of the south wing, a one story wing determined to be of Type V (111) construction and fully sprinkled, and the north wing, a one story wing determined to be Type II (222) construction and fully sprinkled except</p>	K020000	<p>This plan of correction is submitted to serve as a Credible Allegation of compliance in association with stated completion dates. Preparation and/or execution of this plan of correction does not constitute an admission of agreement by the provider or conclusions set facts on the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by State and Federal laws.</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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	<p>the two outside attached emergency generator rooms. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, battery operated smoke detectors in the twelve resident rooms on the North Wing, and hard wired smoke detectors in the fifteen resident rooms on the South Wing which are electrically wired to an audible signal at the nurses' station. The facility has a capacity of 45 and had a census of 25 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled. All areas providing facility services were sprinkled except the two outside attached generator rooms.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/01/31.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K020038 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>Based on observation and interview, the facility failed to ensure 2 of 5 exit doors with delayed egress locks were provided with signs indicating PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided:</p> <p>(a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6.</p> <p>(b) The doors unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release</p>	K020038	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.No residents were affected. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.No residents will be affected.What measures will be put into place or what systemic changes will be made to ensure that the deficient does not recur.Code compliant signs will be place at doors by 11/27/2013. (attachment #5)How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quaility assurance program will be put into place.Code compliant signs will be placed at doors by 11/27/2013. All systemic changes will be completed by 11/27/2013.</p>	11/27/2013			

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	<p>the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) 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 at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS".</p> <p>This deficient practice could affect any residents in the facility who use the main dining room, and 12 residents who reside on the South Wing.</p> <p>Findings include:</p> <p>Based on observation on 10/28/13 during a tour of the South Wing from 12:10 p.m. to 1:30 p.m., the front exit door and the South Wing exit door were provided with a fifteen second delay when force was</p>			

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	<p>applied to the releasing device on each door. Furthermore, the South Wing exit door and front exit door lacked a sign reading, PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS. This was verified by the maintenance supervisor and administrator at the time of observations, and confirmed by the administrator at the exit conference on 10/28/13 at 1:40 p.m.</p> <p>3.1-19(b)</p>			

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K020046 SS=A	<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 observation and interview, the facility failed to ensure 2 of 14 battery backup emergency lights provided at least 1 1/2 hour of emergency lighting. This deficient practice only affects staff using the nurses station medicine room and outside south emergency generator room.</p> <p>Findings include:</p> <p>Based on observations with the administrator and maintenance supervisor during a tour of the facility on 10/28/13 from 9:50 a.m. to 1:30 p.m., the battery backup light in the outside south emergency generator room and the battery backup light in the nurses' station medicine room each failed to light on three separate test attempts. Based on an interview with the maintenance supervisor on 10/28/13 at 12:10 p.m., the two backup light battery packs need replaced. This was verified by the maintenance supervisor and administrator at the time of observations, and confirmed by the administrator at the exit conference on 10/28/13 at 1:40 p.m.</p> <p>3.1-19(b)</p>	K020046	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.No residents were effected by this deficiency. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.No residents have the potential to be affected by this deficiency. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.Emergency light at nurses station will be replaced by 11/27/2013. The emergency light in the emergency generator room will be removed when the building is removed by 11/27/2013. How corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.30 second monthly tests and a 90 minute annual test will be conducted on all emergency light and testing will be logged on Battery-Operated Emergency Light form. (attachement #1) All systemic changes will be completed by 11/27/2013</p>	11/27/2013			

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K020056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 2 of 2 outside attached rooms were sprinkled. This deficient practice could affect all residents in the facility in the event of a fire in the two outside emergency generator rooms.</p> <p>Findings include:</p> <p>Based on observations on 10/28/13 during a tour of the outside of the facility from 10:45 a.m. to 11:30 a.m., the two outside attached emergency generator rooms were not provided with sprinkler coverage. This was verified by the administrator and maintenance supervisor at the time of observations, and confirmed by the administrator at the exit conference on 10/28/13 at 1:40 p.m.</p>	K020056	<p>What corrective actions will be accomplished for those resident found to have been affected by the deficient practice.No residents were affectedhow other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.No residents will be affected What measures willbe put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The emergency generators rooms will be removed by 11/27/2013.How corrected actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.No other corrective action will need to be put into place due to the removal of the 2 emergency generator rooms.All systemic changes will be</p>	11/27/2013			

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	3.1-19(b)		completed by 11/27/2013		

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K020067 SS=E	<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 1 of 3 egress corridors was not being used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply return or exhaust air system serving adjoining areas. This deficient practice affects 14 resident who reside on the Shirley Hall.</p> <p>Findings include:</p> <p>Based on observations on 10/28/13 during a tour of the North Wing from 11:35 a.m. to 12:45 p.m. with the administrator and maintenance supervisor, the North Wing egress corridor was being used as a return air system for twelve resident rooms. This was verified by the administrator and maintenance supervisor at the time of observations, and confirmed by the administrator at the exit conference on 10/28/13 at 1:40 p.m.</p>	K020067	Waiver requested for K-67 Please see attachment #2 for State Form 54147.	11/27/2013			

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K020070 SS=A	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 portable space heating devices was prohibited in a resident room. This deficient practice could affect 1 resident who would occupy the medicare suite resident room 116, which was unoccupied.</p> <p>Findings include:</p> <p>Based on observations on 10/28/13 at 12:10 p.m. with the administrator and maintenance supervisor, the medicare suite resident room 116 had a portable electric fire place with an electric space heating device installed inside the unit. This was verified by the administrator and maintenance supervisor at the time of observation when the electric space heater was turned on, and confirmed by the administrator at the 1:40 p.m. exit conference on 10/28/13. Furthermore, the administrator indicated the facility did not have a written policy for the use of space heaters during the exit conference.</p> <p>3.1-19(b)</p>	K020070	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The portable heating device will be removed from room 116 by 11/27/2013. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. No other residents will be affected by the deficient practice because no portable heating device are used in the facility. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Policy to not allow portable heating devices in any resident rooms attached. (attachment #4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place. Rooms will be evaluated daily during routine cleaning by housekeeping staff to ensure no portable heating devices are present. All systemic changes will be completed by 11/27/2013.</p>	11/27/2013			

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K020074 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 15 of 27 residents rooms were flame retardant. This deficient practice could affect 13 resident who reside on the North Wing and 3 residents who reside on the South Wing in rooms 106, 109, and 111.</p> <p>Findings include:</p> <p>Based on observations with the administrator and maintenance supervisor during a tour of the facility on 10/28/13 from 9:50 a.m. to 1:30 p.m., the twelve resident rooms on North Wing and the South Wing resident rooms 106, 109, and 111 each had a window curtain which</p>	K020074	<p>What corrective actions will be accomplished for those residents found to have been affected by deficient practice.12 resident rooms on the north wing and rooms 106, 109, and 111 all window curtains will be treated with code compliant retardant by 11/27/2013.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.All window curtains will be purchased with code compliant flame retardancey. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.All window curtains will be treated with code compliant</p>	11/27/2013			

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	<p>lacked attached documentation they were inherently flame retardant. Based on interview at the time of observations with the administrator, there was no documentation regarding flame retardancy for window curtains in the North Wing resident rooms and the South Wing resident rooms 106, 109, and 111 available for review. This was confirmed by the administrator at the exit conference on 10/28/13 at 1:40 p.m.</p> <p>3.1-19(b)</p>		<p>retartant and future purchases will be flame retardant code compliant. (attachement #6)How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Document when all current non compliant items are treated and retreat and document when applicable.All systemic changes will be completed by 11/27/2013</p>	

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K020144 SS=F	<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 provide emergency generators with automatic transfer switches to automatically transfer power within 10 seconds of failure of the normal power source. NFPA 99, 3-6.3.1.2 requires the emergency system shall be so arranged that, in the event of failure of normal power source, the alternate source of power shall be automatically connected to the load within 10 seconds. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation of the South Wing and North Wing outside emergency generators with the maintenance supervisor on 10/28/13 at 10:10 a.m., the maintenance supervisor stated the emergency generators are used as supplemental emergency power during power outages for corridor lighting and electrical outlets throughout the facility. Based on an interview with the maintenance supervisor on 10/28/13 at 10:20 a.m., the maintenance supervisor indicated there are no automatic transfer</p>	K020144	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.No residents were effected by this deficiency. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.No residents have the potential to be affected by this deficiency.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.An estimate was secured on 9/5/2013 for a generator with an automatic transfer switch. The code compliant generator will be installed by 4/1/2014. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be but in place.Upon installation of the new code compliant generator required weekly checks will be conducted after installation. All systemic changes will be completed by 4/1/2014.</p>	11/27/2013			

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NAME OF PROVIDER OR SUPPLIER MIDDLETOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 131 S 10TH ST MIDDLETOWN, IN 47356
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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
	<p>switches for the two emergency generators and they have to be turned on manually after a power outage occurs. The lack of automatic transfer switches for the two emergency generators to automatically transfer power during power outages was verified by the maintenance supervisor at the time of observation, and confirmed by the administrator at the exit conference on 10/28/13 at 1:40 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure an alarm annunciator was provided in a location readily observed by operating personnel at a regular work station such as a nurses' station for 2 of 2 emergency generators. 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: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is</p>			

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	<p>malfunctioning.</p> <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"> 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. <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 the residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 10/28/13 at 10:15 a.m. with the maintenance supervisor, a remote alarm annunciator for the two emergency generators was not provided in a location readily observed by operating personnel at a regular work station such as a nurses' station. This was</p>						

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	<p>verified by the maintenance supervisor at the time of observations, and confirmed by the administrator at the exit conference on 10/28/13 at 1:40 p.m.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to exercise the generator for 11 of the past 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator 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> <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</p>						

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	<p>testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Emergency Generator Weekly Inspection Checklist and Load Test Worksheets on 10/28/13 with the maintenance supervisor, the last monthly load test for the two emergency generators was dated 10/09/12. The lack of monthly load tests for the two emergency generators over the past eleven months was verified by the maintenance supervisor at the time of record review, and confirmed by the administrator at the exit conference on 10/28/13 at 1:40 p.m.</p> <p>3.1-19(b)</p>				