

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 10/28/2014
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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: 10/28/14</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. The</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 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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K020025 SS=E	<p>facility has a fire alarm system with smoke detection in the corridors, 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 33 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 11/05/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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</p>			
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	<p>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 observations and interview, the facility failed to ensure the smoke barrier wall above 1 of 3 smoke barrier doors and 1 of 1 ceiling smoke barriers were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice affect maintenance and laundry staff.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor during a tour of the facility on 10/28/14 from 9:35 a.m. to 1:30 p.m., the following smoke barrier walls and ceilings had penetrations not firestopped;</p> <ol style="list-style-type: none"> 1. The boiler room ceiling had two, two inch gaps around a metal exhaust duct penetration with no fire stopping used to seal the gaps. 2. The sprinkler riser room ceiling had a two inch gap around the sprinkler riser 	K020025	<p>WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. ½ hour Fire resistant caulking will be added to the areas of concern by the Maintenance Director. 11/27/2014. HOW OTHER RESIDENT HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN All residents will benefit from the safety assurances provided by the addition of the ½ hour fire resistant caulk to the areas of concern. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR All employees will report all environmental concerns to the Maintenance Director by completing the work requisition form same shift/same day. The Maintenance Director will assure the concerns will be addressed in a timely manner. The Administrator will monitor and assure compliance. HOW THE CORRECTIVE ACTION(S) WILL</p>	11/27/2014

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K020029 SS=E	<p>penetration with no fire stopping used to seal the gap.</p> <p>3. The New Hall smoke barrier wall above the smoke barrier doors had nine, one inch to three inch gaps around six electric conduit penetrations, two cable penetrations and a water pipe penetration with no fire stopping used to seal the gaps.</p> <p>The boiler room ceiling, the sprinkler riser room ceiling, and the New Hall smoke barrier wall above the set of smoke barrier doors not properly fire stopped was verified by the maintenance supervisor at the time of observations and acknowledged by the director of nursing and maintenance supervisor at the exit conference on 10/28/14 at 1:40 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p>		<p>BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE; AND On Monday 11/17/2014 the Administrator will review the maintenance log once weekly for a one month period to assure timely and thorough completion of the reported areas of concern. Thereafter the Administrator will review and monitor on a monthly basis the maintenance log and monthly check list to assure timely and thorough follow through on the reported areas of concern. The results of these interventions will be reviewed and updated with the Quality Assurance Committee quarterly.</p> <p>BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED 11/27/2014</p>	

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	<p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 4 hazardous areas, such as a combustibile storage rooms over 50 square feet in size, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 21 residents who reside on the Old Hall.</p> <p>Findings include:</p> <p>Based on observation on 10/28/14 at 11:10 a.m. with the maintenance supervisor, the Old Hall storage room, which measured one hundred ninety six square feet and stored three cardboard boxes, eight plastic mattresses, lacked a self closing device on the door. The lack of self closing devices on the Old Hall storage room was verified by the maintenance supervisor at the time of observation and acknowledged by the director of nursing and maintenance supervisor at the exit conference on 10/28/14 at 1:40 p.m.</p> <p>3.1-19(b)</p>	K020029	<p>WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE The doors found not in compliance due to lack of a self closing devise were fitted with a spring hinge latch that assures the door will close automatically. The latches were added on November 1, 2014. All doors are now in compliance with regards to the self closiong latches. HOW OTHER RESIDENT HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN. All residents will benefit from the addition of self closing spring hinge latches to the doors affected. All staff will attend an inservice on reporting any self latching doors that are malfunctioning by 11/27/14. All doors requiring self latching devices have been added, checked and verified as in place and working by the Maintenance Director and the Administrator. The Administrator will also review and monitor the completed monthly checklist to assure continued compliance on a monthly basis. The results of the monthly reviews will be updated at the quarterly Quality Assurance Committee meeting.</p> <p>WHAT MEASURES WILL BE</p>	11/27/2014	

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			<p>PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR; All doors requiring self closing spring hinge latches will be checked by the Maintenance Director during the monthly maintenance check of the facility systems. In addition, on a monthly basis the Administrator will assure continued compliance by reviewing and monitoring the monthly maintenance checklist of the facility systems. The monthly maintenance check list will be reviewed quarterly the QA committee and verified. All staff will attend an inservice on reporting any areas requiring fire resistant caulk. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE; AND BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED All doors requiring self latching devises will be checked by the Maintenance Director during the monthly maintenance check of facilities systems beginging November 1, 2014. In addition, on a monthly basis the Administrator will assure continued compliance by reviewing and monitoring the monthly maintenance check list of the facility systems. The monthly</p>	

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			maintenance check list will be reviewed quarterly and the QA committee will discuss and verify quarterly. All doors related to the citing have be corrected as of November 1, 2014.		