

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155486	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/17/2015
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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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K 0000 Bldg. 02	<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: 09/17/15</p> <p>Facility Number: 000343 Provider Number: 155486 AIM Number: 100289600</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 facility has a fire alarm system with smoke detection in the corridors, spaces</p>	K 0000	<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 he provider of conclusion 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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K 0025 SS=F Bldg. 02	<p>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 32 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 completed 09/22/15 - DA</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 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 2 of 4 attic smoke barriers were maintained to provide a one half hour fire resistance rating. This deficient practice could affect all</p>	K 0025	WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE Penetrations through wall will be	10/17/2015			

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	<p>residents in the facility.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 09/17/15 during observations of the attic smoke barriers above the drop ceiling assembly from 1:20 p.m. to 2:20 p.m., the following attic smoke barriers were not fire stopped or had non rated material used as a smoke barrier wall;</p> <p>a. The New Hall attic smoke barrier wall had twelve, one half inch electrical conduit penetrations on both sides of the attic smoke barrier wall with between one inch and three inch gaps around the penetrations not fire stopped.</p> <p>b. The Old Hall attic smoke barrier wall had two, one inch gaps on both sides of the attic smoke barrier wall around electrical conduit penetrations which revealed the attic smoke barrier is constructed of one half inch plywood. Furthermore, the two foot by eight foot long attic smoke barrier wall was covered with drywall compound and painted white to give an appearance of drywall. The New Hall attic smoke barrier wall not fire stopped and the Old Hall attic smoke barrier wall constructed of non rated plywood was verified by the maintenance supervisor at the time of observations and acknowledged by the</p>		<p>fire caulked by maintenance. Wall that was constructed of paneling will be replaced with drywall. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFCTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN All residents will benefit from the application of fire caulk and replacement of the paneling to drywall. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR After completion of any work to the building an inspection of effected areas will be done and fire caulk applied if necessary. Any future construction in the building will be completed with drywall. 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 Maintenance Supervisor will inspect any and all future construction within 24 hours of completion to insure all fire barriers are in place. BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED 10/17/2015</p>				

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K 0130 SS=F Bldg. 02	<p>director of nursing at the exit conference on 09/17/15 at 2:50 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview, the facility failed to ensure 5 of 5 hot water heater/boilers had inspection certificates that were current to ensure the boiler was in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the one New Hall boiler room and the Old Hall boiler room on 09/17/15 during a tour of the facility from 9:40 a.m. to 2:45 p.m. with the maintenance supervisor, the two A O Smith model hot water heater with inspection certificates #232553 and #259135, the Whirlpool model hot water heater with inspection certificate #320979, the Hydrotherm model boiler</p>	K 0130	<p>WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE Call was placed on 9/17/2015 to request inspection of boiler vessels to the State of Indiana. Spoke with Julia Ping and was directed by her to email her and request that an inspected be done. During this call we asked what time frame the inspection would be completed and Julia stated that the department was short on staff and no time frame could be given at this time. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFCTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN All residents will benefit from the safety assurance of the inspection of the boiler vessels. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES</p>	10/17/2015	

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K 0144 SS=F Bldg. 02	<p>with inspection certificate #320979, and the Lochnivar model boiler with inspection certificate #315509 each had an inspection certificate with an expiration date of 06/27/15. Based on an interview with the maintenance supervisor on 09/17/15 at 1:20 p.m., it was stated there is no current two year inspection certificate for the two A O Smith model hot water heaters, the Whirlpool model hot water heater, and the Hydrotherm and Lochnivar model boilers. The lack of current inspection certificate for the two A O Smith model hot water heaters, Whirlpool model hot water heater, and Hydrotherm and Lochnivar model boilers was verified by the maintenance supervisor at the time of record review and acknowledged by the director of nursing at the exit conference on 09/17/15 at 2:50 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and</p>		<p>WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR As of 10/1/2015 boilers still have not been inspected. Call placed to State of Indiana spoke with Malanie Pattenauade was directed by her that a new form has been put into place by the State of Indiana. She emailed a copy to the facility. Form has been completed and returned to her. Malanie said she would forward the form to the inspector of our area to schedule inspection. Future inspection will be requested two (2) months in advance of expiration date to prevent a lapse in certifications. Please see Attachment A for completed form.</p> <p>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 Maintenance Supervisor will include boiler inspection to yearly scheduled inspections. Which will be discussed during quarterly QA meetings as up coming inspections. BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED 10/17/2015</p>				

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	<p>exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator with over 100 horsepower was equipped with a remote manual stop station located in a remote location. NFPA 110, 1999 edition, 3-5.5.6 requires Level I installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on observation on 09/17/15 at 12:45 p.m. with the maintenance supervisor, the emergency generator was located in a metal generator enclosure and was equipped with a manual stop switch mounted on the emergency generator and not at a remote location. Furthermore, based on an interview with the maintenance supervisor on 09/17/15 at 12:55 p.m., the emergency generator is</p>	K 0144	<p>WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE This deficient practice did not effect any resident in the building. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFCTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN This deficient practice did not effect any resident in the building. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR In Power Electrical was contacted 9/29/2015 to add a remote emergency stop button. See attachment B for estimate on work to be completed. 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 During monthly inspection of the generator the button will be inspected to insure that it has not been tampered with and is in working order. BY WHAT DATE</p>	10/17/2015	

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	a one hundred fifty horsepower diesel. The lack of the emergency generator manual stop switch located at a remote location was verified by the maintenance supervisor at the time of observation and acknowledged by the director of nursing at the exit conference on 09/17/15 at 2:50 p.m. 3.1-19(b)		THE SYSTEMIC CHANGES WILL BE COMPLETED 10/17/2015		