

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155414	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/10/2015
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NAME OF PROVIDER OR SUPPLIER LINTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1501 A ST LINTON, IN 47441
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K 0000 Bldg. 01	<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: 08/10/15</p> <p>Facility Number: 000333 Provider Number: 155414 AIM Number: 100288370</p> <p>At this Life Safety Code survey, Linton 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 one story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 38</p>	K 0000	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies</p> <p>This plan of correction is prepared and/or executed solely because required</p> <p>ISDH</p> <p>Dear Ms Rhoades:</p> <p>On August 10, 2015 a Life Safety Code Survey was conducted at Linton Nursing and Rehab Center</p> <p>Please consider this letter and plan of correction to be the facility's credible allegation of compliance</p> <p>I am requesting a desk review to verify that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the plan of correction of September 4, 2015</p> <p>Please call me with any further questions at 812- 847-4426 or directly at 812 296 0695</p> <p>Respectfully, Charlotte Wagoner, HFA</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 0029 SS=F Bldg. 01	<p>and had a census of 27 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except three detached wood sheds used for facility storage.</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>Based on observation and interview, the facility failed to ensure 3 of 4 bathroom/shower rooms, which contained soiled linen containers with a capacity over 32 gallons, were equipped with self closing devices on the corridor doors. This deficient practice could affect any number of residents, as well as staff while in the three bathroom/shower rooms.</p> <p>Findings include:</p>	K 0029	<p>I) No residents were identified as being affected by this practice Self closures will be placed on all 4 resident shower rooms where soiled linen barrels are stored II) All residents showering or using those shower rooms had the potential to be affected by this practice Self closures will be placed on all 4 shower rooms where soiled linen is stored III) Self closures will be added to all 4 shower rooms where soiled linen barrels are stored These closures will be added to the maintenance preventive maintenance log book</p>	09/04/2015

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K 0050 SS=F Bldg. 01	<p>Based on observations on 08/10/15 between 11:00 a.m. and 12:15 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted:</p> <p>a. The Beauty shop/bathroom near the south exit had a soiled linen cart over 32 gallons stored within. The door to the corridor was not provided with a self closing device.</p> <p>b. The bathroom/shower room across from rooms 17 and 18 had a soiled linen cart over 32 gallons stored within. The door to the corridor was not provided with a self closing device.</p> <p>c. The bathroom/shower room across from room 1 had a soiled linen cart over 32 gallons stored within. The door to the corridor was not provided with a self closing device.</p> <p>This was acknowledged by the Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are</p>		<p>IV) Maintenance/Designee will monitor 5xweekly x 2 weeks, weekly x2 weeks, monthly thereafter to ensure door closures are working properly The log will be taken to QA committee quarterly x4 for any further recommendations Date Certain: Sept 4, 2015</p>				

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K 0064 SS=C Bldg. 01	<p>conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 2 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Life Safety Manual on 08/10/15 at 10:00 a.m. with the Administrator and Maintenance Director present, the facility lacked written documentation fire drills were conducted during the first (day) and second (evening) shifts of the second quarter (April, May, and June) of 2015. This was confirmed by the Maintenance Director at the time of record review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to inspect 3 of 7 portable fire extinguishers throughout the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher</p>	K 0050	<p>I) No residents were found to have been affected by this practice Maintenance performed fire drills but failed to document for his log book Maintenance has been re-educated on importance of the fire drill documentation</p> <p>II) All residents have potential to be affected by this practice Fire Drill documentation will be completed for every drill and placed immediately in the maintenance log book</p> <p>III) Systemic change will be that maintenance will develop a calendar for proposed monthly drills per calendar year and the administrator will do audits of the maintenance log book</p> <p>IV) Administrator will audit the maintenance log book for compliance and documentation of fire drills monthly x12 months and take to QA quarterly x4 Date Certain: 9/4/2015</p>	09/04/2015			
		K 0064	<p>I) No residents were found to be affected by this practice II) All residents had the potential to be affected by this practice Maintenance will develop a floor plan with the areas of the fire extinguishers numbered There</p>	09/04/2015			

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K 0144	<p>inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect any number of residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations of fire extinguisher tags on 08/10/15 between 11:00 a.m. and 12:15 p.m. during a tour of the facility with the Maintenance Director, the fire extinguishers in the front hall near the Administrator's office, the boiler room, and at the outside gazebo where residents and staff smoke had not had their monthly inspection in July of 2015. This was confirmed by the Maintenance Director at the time of each observation.</p> <p>3.1-19(b) NFPA 101</p>		<p>will be a check off list at the bottom with the extinguishers number for maintenance to check off as he inspects the fire extinguishers III) The maintenance director will use his map and check off tool (#11)each month and report to administrator when complete IV) Administrator will monitor completion of this task monthly x12 and present findings to QA quarterly x 4 for further recommendations Date Certain: 9/4/15</p>		

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SS=F Bldg. 01	<p>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 interview and record review, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires weekly maintenance of the emergency generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-3.6 requires storage batteries used for generator sets in Level 1 and 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review on 08/10/15 at</p>	K 0144	<p>I) No residents were found to be affected by this practice II) All residents had the potential to be affected by this practice Maintenance has been re-educated on the time frame to test the generator and the importance of completing task and proper timely documentation III) Maintenance will develop a yearly calendar to reflect the monthly plan for the load test of the generator and present to the Administrator IV The Administrator will monitor the plan and generator load test check off sheet each month x12 months and will present results to the QA committee quarterly x4 for further recommendations Date certain: Sept 4, 2015</p>	09/04/2015			

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	<p>10:45 a.m. with the Administrator and the Maintenance Director present, the most recent Weekly Generator System Service and Testing report was dated 06/19/15. This was confirmed by the Maintenance Director at the time of record review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to load test the generator for 3 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</p>			

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	<p>exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the monthly load test portion of the Weekly Generator System Service and Testing documentation on 08/10/15 at 10:45 a.m. with the Administrator and the Maintenance Director present, the most recent monthly load test documented was dated 04/22/15. There was no documentation a load test was performed during May, June, and July of 2015. This was confirmed by the Maintenance Director at the time of record review.</p> <p>3.1-19(b)</p>				