STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE-INN	140 W WASHINGTON ST MORGANTOWN, IN 46160

(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
K010000	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). Survey Date: 04/18/13 Facility Number: 000399 Provider Number: 155750 AIM Number: 100289100 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Morgantown Health Care-Inn 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. This one story facility with a basement was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridor. The facility has battery operated smoke detectors installed	K010000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	in all resident sleeping rooms. The facility has a capacity of 39 and had a census of 37 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing storage services which was not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/22/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010046 SS=C	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. 1. Based on record review, observation, and interview; the facility failed to document monthly testing of emergency lighting in accordance with LSC 7.9 for 11 of 12 months. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted at 30 day intervals for battery powered emergency lighting systems. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Yearly Emergency Light Test" documentation dated 03/20/13 with the Environmental Supervisor during record review from 11:25 a.m. to 1:10 p.m. on 04/18/13, an itemized list of functional testing of 15 battery operated emergency lights in the facility was not available for review for April 2012 through February 2013. Based on interview at the time of record review, the Environmental Supervisor acknowledged	K010046	1. Enironmental Supervisor and staff in-serviced and re-educated on the importance of having functional testing of all battery operated emergency light.2. Any resident has the potential to be affected.3. New batteries have been installed as of 4/23/13. E.S. has incorporated new form provided by Life Safety. Form includes itemized list of functional testing.4. E.S. to report to Q. A. for 6 months. Q.A. to monitor for 6 months.5. Completed 4/23/13.	04/23/2013

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	an itemized list of functional testing of 15 battery operated emergency lights in the facility was not available for review for April 2012 through February 2013. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 15 battery operated emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.4 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect all occupants in the facility. Findings include: Based on observations with the Environmental Supervisor during a tour of the facility from 11:25 a.m. to 1:10 p.m. on 04/18/13, the battery operated emergency light at the Dining Room exit door and in the corridor by Room 6 each failed to illuminate when the test button was pressed five times. Based on interview at the time of the observations, the Environmental Supervisor stated			

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	replacement batteries had been ordered but acknowledged the aforementioned battery operated emergency lights failed to illuminate when the test button was pressed. 3.1-19(b)			

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K010062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure 3 of over 100 sprinkler heads in the facility were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect 28 residents, staff and visitors. Findings include: Based on observations with the Environmental Supervisor during a tour of the facility from 11:25 a.m. to 1:10 p.m. on 04/18/13, the following areas each had missing escutcheon plates which left a two inch opening in the ceiling into the attic from each area: a. in the bathroom for resident Room 25. b. in the closet for the bathroom in Room 25. c. in the Med Room at the Nurse's Station. Based on interview at the time of the observations, the Environmental Supervisor acknowledged the sprinkler heads in the aforementioned locations	K010062	1. Staff was in-serviced immediately about the escutcheon plates. Superior Systems was contacted immediately on 4/18/13.2. Any resident has the potential to be affected.3. Superior Systems replaced the escutcheion plates on 4/26/13.4. E. S. to check monthly and report to Q. A. for six months. Repair and replace as identified. Q. A. to monitor for six months.5. Completed 4/26/13.	04/26/2013

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	each had missing escutcheon plates which left a two inch opening in the ceiling into the attic from each area. 3.1-19(b)			

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K010130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 26 of 26 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Smoke Detector Log for Resident Rooms" documentation with the Environmental Supervisor during record review from 9:10 a.m. to 11:25 a.m. on 04/18/13, an itemized listing of monthly battery operated smoke detector testing for each resident sleeping room location was not available for review for February and March 2013. The aforementioned documentation itemized the results of monthly checks of battery operated smoke detectors in each resident sleeping room for the period July 2012 through January 2013. In addition, a review of "Smoke Detector Daily Checks and Weekly Cleaning" documentation for February and March 2013 did not list the	K010130	1. In-serviced staff on Smoke Detector Log and proper record keeping.2. Any resident has the potential to be affected.3. E. S. to receive monthly all documents that are completed for proper storage so that documentation can be presented as needed.4. E. S. to check monthly for documented report sheets for 6 months. Q. A. to monitor for 6 months.5. Completed 5/1/13.	05/01/2013

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	results of monthly battery operated smoke detector testing for each resident sleeping room location for February and March 2013. Based on interview at the time of record review, the Environmental Supervisor acknowledged documentation of an itemized listing of monthly battery operated smoke detector testing for each resident sleeping room location for February and March 2013 was not available for review. Based on observations with the Environmental Supervisor during a tour of the facility from 11:25 a.m. to 1:10 p.m. on 04/18/13, battery operated smoke detectors were installed in each of the 26 resident sleeping rooms. 3.1-19(a)			