STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155464	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKVILLE NURSING AND REHABILITATION CENTER	768 N US HWY 41 ROCKVILLE, IN 47872

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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: 06/25/14 Facility Number: 000492 Provider Number: 155464 AIM Number: 100291360 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Rockville 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. This one story, fully sprinklered facility determined to be of Type II (111) construction with an attached covered front entry porch of Type V (000) construction which was fully sprinklered. The facility was considered Type V (000)	K010000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective July 25, 2014 to the Life Safety Code Survey conducted on June 25, 2014. We respectfully request a paper review. We will provide you with any additional information to confirm compliance per your request.	

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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	construction for the purpose of this survey. The facility has a fire alarm system with hard wired smoke detection in the corridors and in spaces open to the corridors. Battery powered smoke detectors are provided in all resident rooms. The facility has a capacity of 38 and had a census of 34 at the time of this survey. All areas accessible to residents were sprinklered . All areas providing facility services were sprinklered except three detached structures housing storage and a maintenance area. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/03/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a single	K010048	**K048 It is the practice of this facility to assure that there is a**	07/19/2014

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	written fire safety plan addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants in the event of an emergency when the written fire plan should be immediately available. Findings include: Based on record review with the maintenance director and administrator on 06/25/14 at 10:50 a.m., required elements of the policy and procedure for the written Fire Plan were missing or found in different and separate places. Three documents were located in the disaster manual available to staff for training and direction in the event of fire: Fire Policy and Procedure, Emergency Fire Procedure, and IN CASE OF FIRE		**written plan for the protection of all patients and for their evacuation in the event of an emergency.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** The Disaster Manual has been revised to assure the protection of our residents in the event of a fire. ***Other residents that have the potential to be affected have been identified by:*** All residents, visitors and staff had the potential to be affected, but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** An in-service has been conducted with all staff to clarify the Fire Policy and Procedure in the Disaster Manual. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews the Fire Policy and Procedure in the Disaster Manual. The Administrator or designee will complete this tool weekly x 3, monthly x 3, and quarterly x 3. Any issues identified will be immediately reviewed and appropriate action taken. The Quality Assurance Committee will review the Performance Improvement Tool at the scheduled meetings with	

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	"procedure to be followed." The Fire Policy and Procedure directed staff to rescue anyone in immediate danger and then alert others by pulling the fire alarm. The Emergency Fire Procedure directed staff to 1. stay calm, 2. contain the fire by smothering or if too large and safety permits, use a fire extinguisher to put out the fire, 3. remove residents from immediate area. The IN CASE OF FIRE version of the fire procedure directs staff, "if fire is in occupied room, and cannot be extinguished instantly: remove resident to corridor. Additionally, the list of fire extinguishers available in the facility did not include the K-class extinguisher, it's location and special instructions for use in relationship with the use of the kitchen hood extinguishing system. The administrator said at the time of record review, the multiple policies should not have been included in the facility disaster manual and acknowledged the response sequence for each should have addressed the evacuation of residents before any fire fighting was attempted. 3.1-19(b)		recommendations as needed based on the outcomes of the tools ***The date the systemic changes will be completed: July*** 19, 2014	
K010067	NFPA 101			

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SS=F	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 Based on observation, record review and interview; the facility failed to maintain 1 of 1 central air conditioning cooling towers in accordance with manufacturer's specifications. This deficient practice affects all occupants. Findings include: Based on observation with the maintenance director on 06/25/14 at 9:45 a.m., a steady misty shower of water spewed from the top of the central air cooling tower providing air conditioning for residents in the corridors and common areas such as the dining room. The water was falling on anyone walking and collecting on the exit discharge sidewalk. Water was leaking from the top and upper sides of the cooling tower and running down the sides of the unit. The maintenance director said at the time of observation, this was not the way the unit was designed to operate. Four louvered covers laid on the ground adjacent to the cooling tower. The maintenance director said these were designed to be secured to the top of the central air cooling tower. The maintenance director said at the time	K010067	**K067 It is the practice of this facility to assure that heating, ventilating, and air conditioning are installed and maintained in accordance with manufacturer's specifications.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** CLR rust and lime remover was obtained and the cooling tower was cleaned. The 4 louvered covers have been sand blasted, painted and installed into the cooling tower. There is no longer water spraying or leaking from the cooling tower. ***Other residents that have the potential to be affected havebeen identified by:*** All residents, visitors and staff had the potential to be affected, but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Maintenance Director has been in-serviced on the importance of following the manufacturer's specifications.	07/19/2014

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	of observation, the cooling tower required constant monitoring for malfunction because the unit was badly limed up. He said this condition caused stress on the operating systems. He said his regional maintenance director was "trying to get chemicals" for the system. He said his HVAC contractor had replaced a circulating pump motor in 2013 and a belt this year but had told him the tower needed to be replaced. A review of the preventive maintenance records with the maintenance director on 06/25/14 at 10:25 a.m. did not include a maintenance program for the cooling tower. The maintenance director said at the time of record review, he kept an eye on the unit and tried to clean what he could to ensure it worked but he made no documentation for review. A review of the Operating and Maintenance Instructions for the tower noted a program of regular inspection and maintenance was recommended for the the unit and all recommendations on frequency of service were "minimums." A table on page five documented monthly, biannual and annual inspection and maintenance procedures to maintain the unit. The document covered general water guidelines and a section titled Chemical Treatment on page 10 of the document said, "if the condition of the water is such that constant bleed will not		The facility has obtained approval to replace the cooling tower. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews manufacturers specifications are followed in maintaining the cooling tower, checking for appropriate agents for de-liming until new system is acquired. The Administrator or designee will complete this tool weekly x 3, and monthly x 3, and quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools ***The date the systemic changes will be completed: July 19*, 2014**	

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	control scale or corrosion and maintain the general water guidelines, chemical treatment may be necessary." 3.1-19(b)			
K010076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 1 exterior oxygen supply storage locations was protected from abnormal mechanical shock. NFPA 99, 4-3.5.2(b)13 requires oxygen cylinders shall be protected from abnormal shock, which is liable to damage the cylinder, valve, or safety device. Such cylinders shall not be stored in locations where heavy moving objects will strike them. This deficient practice could affect any visitor, resident and staff accessing the parking lot.	K010076	**K076 It is the practice of this facility to assure that medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities** ***The correction action taken for those residents found to beaffected by the deficient practice include:*** A new storage shed has been built for oxygen storage only. ***Other residents that have the***	07/19/2014

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	Findings include: Based on observation with the maintenance director on 06/25/14 at 9:05 a.m., six oxygen e-cylinders were stored in a metal shed located on the north side of the parking lot. The east corner of the shed was visibly damaged, dented at the level of a car bumper. Concrete blocks had been stacked to that level in front of the damaged area. The maintenance director said at the time of observation, the building had been hit by a vehicle and it was "a good thing" the cylinders were stored "on the other side" inside the shed. In addition, the enclosure was filled to capacity with wheelchairs, walkers, and head boards which were haphazardly stored adjacent to and on top of the oxygen cylinders. The maintenance director agreed at the time of observation, the oxygen was not well protected from damage. 3.1-19(b)		***potential to be affected have been identified by:*** All residents,visitors and staff had the potential to be affected, but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Maintenance Director has been re-educated to check oxygen storage during walking rounds to ensure oxygen is stored properly and that there is not any damage to the structure. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews oxygen storage. The Administratoror designee will complete this tool weekly x 3, and monthly x 3, and quarterlyx 3. Any issues identified will be immediately corrected. The QualityAssurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. ***The date the systemic changes will be completed: July 19, 2014***	
K010147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD			

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	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 1 staff and any visitors in the kitchen. Findings include: Based on observation with the maintenance director on 06/25/14 at 9:30 a.m., an extension cord was used to supply power to the refrigerator in the kitchen. The maintenance director said at the time of observation, the cord allowed the refrigerator to be supplied power from and outlet connected to the emergency generator. 3.1-19(b)	K010147	**K147 It is the practice of this facility to assure that electrical wiring and equipment is in accordance with NFPA 70, National Electrical Cole. 9.1.2, flexible cords were not used as a substitute for fixed wiring** ***The correction action taken for those residents found to be affected by the deficient practice include:*** In the dietary department the existing cord was replaced on the refrigerator to reach the generator outlet properly. An extension cord is no longer used. ***Other residents that have the potential to be affected have been identified by:*** All residents, visitors and staff had the potential to be affected, but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All staff have been re-educated on extension cords and that they are not to be used as a substitute for fixed wiring. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement	07/19/2014

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			Tool has been initiated that during walking rounds, random areas in the facility are reviewed to assure extension cords are not being used in the facility. The Administrator or designee will complete this tool weekly x 3, monthly x 3, and quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool. ***The date the systemic changes will becompleted: July 19, 2014***	