

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155765	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/08/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SOUTHERN INDIANA REHAB HOSPITAL-PCU	STREET ADDRESS, CITY, STATE, ZIP CODE 3104 BLACKISTON BLVD PROGRESSIVE CARE UNIT NEW ALBANY, IN 47150
-------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

K 000  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: 04/08/15</p> <p>Facility Number: 005649 Provider Number: 155765 AIM Number: NA</p> <p>At this Life Safety Code survey, Southern Indiana Rehab Hospital-PCU was found not in compliance with Requirements for Participation in Medicare, 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, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 26 and had a census of 17 at the time of this survey.</p>	K 000		
-----------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155765	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/08/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SOUTHERN INDIANA REHAB HOSPITAL-PCU	STREET ADDRESS, CITY, STATE, ZIP CODE 3104 BLACKISTON BLVD PROGRESSIVE CARE UNIT NEW ALBANY, IN 47150
-------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------

(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
K 050 SS=C Bldg. 01	<p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except one metal building building used for facility storage.</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 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 ensure each documented fire drill included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department for 12 of 12 fire drills. LSC 19.7.1.2 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. 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</p>	K 050	<p>Southern Indiana Hospital has always included transmission of the fire alarm signal and simulation of emergency conditions per LSC 19.7.1.2. Process Change: The leader responsible for conducting fire drills added the transmission verification language requested by the Life Safety Code Surveyor during the April 8, 2015 survey. Additional language added to the Drill Observation Form includes time and identification of person receiving the alarm transmission signal. The requested additional verification process change has been added to the hospital's fire drill policies and procedures. The Administrator will review and</p>	04/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155765	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/08/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SOUTHERN INDIANA REHAB HOSPITAL-PCU	STREET ADDRESS, CITY, STATE, ZIP CODE 3104 BLACKISTON BLVD PROGRESSIVE CARE UNIT NEW ALBANY, IN 47150
-------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------

(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
K 062 SS=F Bldg. 01	<p>on 04/08/15 at 11:24 a.m. with the Administrator, Director of Support Services, and Assistant Director of Support Services present, the fire drill form the facility uses did not include information such as the name of the person spoken to at the monitoring company and the time the transmission of the fire alarm was received. Based on interview at the time of record review, the Administrator acknowledged documentation for the transmission of the fire alarm to the monitoring company was not complete information.</p> <p>3-1.19(b)</p> <p>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</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping system was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause</p>	K 062	<p>initial each fire drill form for one calendar year beginning 4/22/2015 to monitor the requested additional verification process. Findings will be reported to the hospital's quality council quarterly for one calendar year.</p> <p>Simplex Grinnell was contacted on April 17, 2015 upon receipt of CMS-2567, and is scheduled to conduct an internal pipe inspection on 5/15/2015.</p> <p>The 5 year inspection will be added to Simplex Grinnell schedule of services for Southern Indiana Rehab Hospital. The 5 year inspection will also be added to the hospital's preventative maintenance calendar for compliance to the NFPA 25</p>	05/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155765	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/08/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SOUTHERN INDIANA REHAB HOSPITAL-PCU	STREET ADDRESS, CITY, STATE, ZIP CODE 3104 BLACKISTON BLVD PROGRESSIVE CARE UNIT NEW ALBANY, IN 47150
-------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------

(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
	<p>obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of sprinkler system inspection reports on 04/08/15 at 11:45 a.m. with the Administrator, Director of Support Services, and Assistant Director of Support Services present, there was no documentation to show the sprinkler system had ever had an internal pipe inspection. Based on an interview at the time of record review, the Administrator acknowledged the sprinkler system has never had an internal pipe inspection.</p> <p>3-1.19(b)</p>		<p>standard.</p> <p>The administrator will review the inspection report and report findings to the hospital's quality council.</p>	