

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/05/2012
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NAME OF PROVIDER OR SUPPLIER  PROFESSIONAL CARE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523
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K0000	<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: 06/05/12</p> <p>Facility Number: 000254 Provider Number: 155363 AIM Number: 100266270</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Professional Care 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 V (000)</p>	K0000	Preparation and/or Execution of this Plan of Correction in general, or any corrective action set forth herein, in particular, does not constitute an admission or agreement by Professional Care Rehabilitation of the facts alleged or the conclusions set forth in the Statement of Deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed solely because of provisions of Federal and/or State laws. Professional Care Rehabilitation desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on June 29, 2012.	

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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	<p>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Resident rooms are not provided with smoke detection. The facility has a capacity of 53 and had a census of 40 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/06/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 10 hazardous area room doors such as kitchen service doors were held open only by devices arranged to automatically close upon activation of the fire alarm system. This deficient practice could affect any of the 40 residents as well as staff and visitors while in the dining room.</p> <p>Findings include:</p> <p>Based on observation on 06/05/12 at 11:50 a.m. during a tour of the facility with the Maintenance Director, the two metal rolling doors for the kitchen</p>	K0021	<p>Upon further review by Maintenance Director and Vanguard Alarm Services on 6-13-12 it was determined 2 kitchen metal rolling doors for kitchen service windows currently are equipped with the proper mechanical hardware to automatically close upon activation of the fire alarm system. In addition, it was found the mechanisms to close the doors were not provided connection to the fire alarm system. On 6-14-12 Vanguard Alarm Services installed the proper electric connection to enable the 2 metal rolling doors to the kitchen service window to close upon the activation of the fire alarm system. Maintenance Director will ensure the doors will close when the fire alarm is actuated. Kitchen Staff will be re-educated to be aware in the</p>	06/22/2012	

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	<p>service windows were held open with chains and fusible links which would not allow the doors to close automatically when the fire alarm system is actuated. This was acknowledged by the Maintenance Director at the time of observation, furthermore, the Maintenance Director indicated the metal roller doors could only be closed manually.</p> <p>3.1-19(b)</p>		<p>event the fire alarm system is activated that the doors will automatically close. Staff will also be educated to keep the countertop under the door ways free from any kitchenware so the doors will close completely. During monthly fire drills Maintenance Director will ensure the doors close upon activating the fire alarm system. Results of the above audits will be forwarded to the QPI committee for review and further recommendations as deemed appropriate until resolved. Responsible person is HFA</p>		

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K0046 SS=F	<p>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.</p> <p>Based on observation and interview, the facility failed to ensure the exterior exit discharge path for 4 of 4 emergency exits was provided with emergency powered egress lighting. LSC 7.9.1.1 requires emergency lighting be provided for means of egress, including walkways leading to a public way. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 06/05/12 between 11:30 a.m. to 1:15 p.m. during a tour of the facility with the Maintenance Director, all four exterior exit discharge areas were provided with light fixtures with at least two bulbs provided, however, during interview the Maintenance Director said the light fixtures were not connected to the emergency generator and were only connected to the regular power</p>	K0046	<p>Upon further review by Maintenance Director and it was determined that 4 out of 4 exterior lights are currently wired and have a breaker in located in the emergency panel. It was determined that 1 out of 4 lights require repositioning to properly illuminate the discharge area. A vendor had been secured to reposition the light fixture for the one entrance. Maintenance will monitor the outside lighting is working properly by ensuring the lights turn on when activated by the internal photo sensor. Results of the above audits will be forwarded to the QPI committee for review and further recommendations as deemed appropriate until resolved. Responsible person is HFA</p>	06/30/2012			

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	<p>supply. He further indicated if the regular power supply was out of service, there would by no light provided outside each of the four exits.</p> <p>3.1-19(b)</p>			