

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155486	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 07/12/2012
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NAME OF PROVIDER OR SUPPLIER MIDDLETOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 131 S 10TH ST MIDDLETOWN, IN 47356
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/12/12</p> <p>Facility Number: 000343 Provider Number: 155486 AIM Number: 100289600</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Middletown 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 facility consisted of the south wing, a one story wing determined to be of Type V (111) construction and fully sprinklered, and the north wing, a one story wing determined to be Type II (222)</p>	K0000	<p>This plan of correction is submitted to serve as a Credible Allegation of compliance in association with stated completion dates. Preparation and/or execution of this plan of correction does not constitute an admission of agreement by the provider of conclusions set facts on the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by State and Federal Laws.</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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	<p>construction and partially sprinklered.</p> <p>The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms which are electrically wired to an audible signal at the nurses' station. The facility has a capacity of 45 and had a census of 28 at the time of this visit.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage, but it was in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where residents have customary access were not sprinklered including the Shirley Hall main dining room above the sidewall mounted sprinkler heads to the ceiling, the administrator office, the Shirley Hall exit foyer near the employee breakroom Resident rooms 2, 3, 4, 5, 9, 10, and 11 entrance hall leading into each room and the beauty shop area above the bulkhead.</p> <p>All areas providing facility services were not sprinklered including the employee breakroom, the kitchen food preparation room, the nurses station storage closet, and the Shirley Hall air handler room.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/23/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory</p>			

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	requirements as evidenced by the following:			

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K0029 SS=E	<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 the corridor door to 1 of 6 Shirley Hall hazardous areas such as a storage room with combustibles over fifty square feet in size was provided with a self closing device which would not prop the door in the open position. This deficient practice could affect 16 residents who reside on the Shirley Hall.</p> <p>Findings include:</p> <p>Based on observation on 07/12/12 at 11:50 a.m. with the maintenance supervisor, the Shirley Hall nursing storage room which measured two hundred forty square feet in size and stored combustible cardboard boxes of paper and plastic nursing supplies was provided with a self closing device which propped the door in the open position. Based on an interview with the</p>	K0029	A proper door closure will be installed at nursing storage	08/11/2012	

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	<p>maintenance supervisor on 07/12/12 at 11:55 a.m., the self closing device on the nursing storage room is a residential type closer with a mechanism installed that clicks when the door is open, allowing the door to prop in the open position. This was verified by the maintenance supervisor at the time of observation and acknowledged by the Director of Nursing at the exit conference on 07/12/12 at 1:00 p.m.</p> <p>3.1-19(b)</p>			

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K0046 SS=C	<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 record review and interview, the facility failed to ensure the annual 90 minute test for 1 of 1 battery backup emergency lights was recorded accurately for the annual 90 minute testing requirement. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. 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 in the facility.</p> <p>Findings include:</p> <p>Based on record review on 07/12/12 at 9:45 a.m. with the maintenance director, the Middletown Nursing and Rehabilitation Center Battery Operated Emergency Light Testing Log was</p>	K0046	new battery operated log see attached	08/11/2012			

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	<p>reviewed for the years 2011 through 2012. The year 2011 log showed an annual 90 minute test conducted in a column to the right of the monthly tests conducted over the 2011 twelve month period. The 2012 log showed monthly tests conducted from January through June, but the column for the annual test was labeled 90 Second Test instead of the required 90 minute test. The mislabeled 2012 Middletown Nursing and Rehabilitation Center Battery Operated Emergency Light Testing Log was verified by the maintenance supervisor at the time of record review and acknowledged by the Director of Nursing at the exit conference on 07/12/12 at 1:00 p.m.</p> <p>3.1--19(b)</p>				

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K0048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>Based on record review and interview, the facility failed to include the use of the alarm, the transmission of the alarm to the fire department, response to alarms, isolation of fire, evacuation of the immediate area and smoke compartments, preparation of building for evacuation and the use of the kitchen portable fire extinguisher in the written plan for the protection of 28 of 28 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (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 <p>This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on a review of the facility's written</p>	K0048	see attached disaster plan update	08/11/2012			

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	<p>fire disaster plan labeled Middletown Nursing and Rehabilitation Center Emergency Fire Procedures on 07/12/12 at 9:50 a.m. with the maintenance supervisor, the Emergency Fire Procedures did not address the use of the fire alarm system, the transmission of the alarm to the fire department, the isolation of fire, evacuation of the immediate area and the smoke compartments, and the use of fire extinguishers including the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on an interview with the maintenance supervisor and director of nursing on 07/12/12 at 1:00 p.m., the Middletown Nursing and Rehabilitation Center Emergency Fire Procedure plan is an old policy and the newest written policy could not be located at this time. This was verified by the director of nursing at the time of interview.</p> <p>3.1-19(b)</p>				

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K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 corridors were completely sprinklered. This deficient practice affects 16 residents who reside on the Shirley Hall.</p> <p>Findings include:</p> <p>Based on observations on 07/12/12 during a tour of the Shirley Hall from 10:25 a.m. to 11:45 a.m. with the maintenance supervisor, the following locations were not provided with complete sprinkler coverage:</p> <p>a. The Shirley Hall main dining room had sidewall mounted sprinkler heads located four feet below the ceiling on the west wall with no sprinkler coverage above the sidewall sprinklers including the ceiling.</p> <p>b. The administrator office had one</p>	K0056	see attachment labled sprinkler system	08/11/2012			

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	<p>sidewall mounted sprinkler on the south wall covering the east portion of the room with no sprinkler coverage around the corner of the room in a fifteen foot by twelve foot area blocked by the wall where the sidewall sprinkler was located.</p> <p>c. The Shirley Hall exit foyer near the employee breakroom, which measured seven foot by five foot, was not provided with sprinkler coverage.</p> <p>d. The employee breakroom which measured fifteen foot by sixteen foot was not provided with sprinkler coverage.</p> <p>e. The kitchen food preparation room which measured fifteen foot by sixteen foot had one sidewall mounted head centered on the south wall. Based on an interview with the maintenance supervisor on 07/12/12 at 11:10 a.m. and observation of a sidewall sprinkler, there was no indication the sidewall sprinklers used were extended coverage heads providing full coverage over this large area.</p> <p>f. Resident rooms 2, 3, 4, 5, 9, 10, and 11 each had one sidewall sprinkler installed in the living portion of the room and the nine foot by eight foot entrance hall into each room was not provided with sprinkler coverage.</p> <p>g. The nurses station storage closet, which measured four foot by six foot, was not provided with sprinkler coverage.</p> <p>h. The Shirley Hall air handler room was</p>			

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	<p>not provided with sprinkler coverage.</p> <p>i. The beauty shop had a four foot by five foot bulkhead constructed near the entrance to the room with a sidewall sprinkler mounted below the bulkhead. The four foot area above the bulkhead to the ceiling was not provided with sprinkler coverage.</p> <p>The areas listed above not being provided with complete sprinkler coverage were verified by the maintenance supervisor at the time of observations and acknowledged by the Director of Nursing at the exit conference on 07/12/12 at 1:00 p.m.</p> <p>3.1-19(b) 3.1-19(ff)</p>				

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K0067 SS=E	<p>NFPA 101 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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 egress corridors was not being used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply return or exhaust air system serving adjoining areas. This deficient practice affects 14 resident who reside on the Shirley Hall.</p> <p>Findings include:</p> <p>Based on observations on 07/12/12 during a tour of the Shirley Hall from 10:35 a.m. to 11:25 a.m. with the maintenance supervisor, the Shirley Hall egress corridor was being used as a return air system for seven resident rooms. This was verified by the maintenance supervisor at the time of observations and acknowledged by the Director of Nursing at the exit conference on 07/12/12 at 1:00 p.m.</p>	K0067	Waiver request for K-67.Please see attachement for written request.	08/11/2012			

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K0144 SS=F	<p>NFPA 101 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>Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 52 of the past 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical 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. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. 6-4.1 requires Level 1 and Level 2 EPSS, including all appurtenant components, shall be inspected weekly and shall be exercised under load monthly at a minimum. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p>	K0144	see attached generator form	08/11/2012

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	<p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 07/12/12 at 10:10 a.m., there was no record of weekly storage battery tests and weekly inspections of the three generator sets for any week over the past year. This was verified by the maintenance supervisor at the time of record review and acknowledged by the Director of Nursing at the exit conference on 07/12/12 at 1:00 p.m.</p> <p>3.1-19(b)</p>				

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K0154 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a written policy in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, standard for Inspection, Testing and maintenance of water-Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned and lastly 11-7 requires notification of everyone again when the system is</p>	K0154	see attached fire watch policy	08/11/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155486	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 07/12/2012
NAME OF PROVIDER OR SUPPLIER MIDDLETOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 131 S 10TH ST MIDDLETOWN, IN 47356		
(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>restored. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review and interview on 07/12/12 at 12:50 p.m. with the maintenance supervisor and Director of Nursing, the facility did not have a written policy in the event the automatic sprinkler system has to be placed out of service for four hours or more in a twenty four hour period. The only documentation provided was a fifteen minute tracking form for staff to sign off on when a fire watch procedure was implemented. The lack of a written policy in the event the automatic sprinkler system has to be placed out of service for four hours or more in a twenty four hour period was acknowledged by the Director of Nursing at the exit conference on 07/12/12 at 1:00 p.m.</p> <p>3.1-19(b)</p>				

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K0155 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a written policy for the protection of 28 of 28 residents in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review and interview on 07/12/12 at 12:50 p.m. with the maintenance supervisor and Director of Nursing, the facility did not have a written policy in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period. The only documentation provided was a fifteen minute tracking form for</p>	K0155	see attached fire watch policy	08/11/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155486	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 07/12/2012
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	<p>staff to sign off on when a fire watch procedure was implemented. The lack of a written policy in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period was acknowledged by the Director of Nursing at the exit conference on 07/12/12 at 1:00 p.m.</p> <p>3.1-19(b)</p>			