

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155697	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/18/2013
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NAME OF PROVIDER OR SUPPLIER  CLARK REHABILITATION AND SKILLED NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129
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K010000	<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: 06/18/13</p> <p>Facility Number: 000059 Provider Number: 155697 AIM Number: 100266560</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Clark Rehabilitation and Skilled Nursing 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) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in</p>	K010000		

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>all resident sleeping rooms. The facility has a capacity of 83 and had a census of 68 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except the water softener room.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/19/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010017 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 open use areas was separated from the corridor, or met an Exception. LSC 19.3.6.1, Exception # 1, Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke</p>	K010017	<p>K017 1-No facility occupants were harmed. The Restorative Dining area will be protected by the placement of an electrically supervised automatic smoke detector by IEI. 2-All facility occupants are at risk. The Restorative Dining area will be protected by the placement of an electrically supervised automatic smoke detector by IEI. 3-The Restorative Dining area will be protected by the placement of an electrically supervised automatic smoke detector by IEI. Any remodeling performed will include smoke detector installation according to regulations and will be overseen by the Maintenance Director or designee. 4-Facility smoke detectors are routinely monitored and tested through the preventative maintenance program by the Maintenance</p>	07/18/2013			

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	<p>detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice affects 25 residents who reside on the 20 Hall and use the restorative dining room, which is located at the south east end of the 20 Hall.</p> <p>Findings include:</p> <p>Based on observation on 06/18/13 at 12:15 p.m. with the maintenance supervisor, the 20 Hall restorative dining room was open to the corridor. Furthermore, Exception # 1, requirement (c) of the Life Safety Code, Chapter 19.3.6.1 was not met as follows: the open area was not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 06/18/13 at 1:20 p.m..</p> <p>3.1-19(b)</p>		Director or designee. All findings will be included in the facility's Continuous Quality Improvement Program and plan of action adjusted accordingly if 100% compliance is not achieved.				

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 40 residents who use the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 06/18/13 during a tour of the facility from 9:45 a.m. to 1:20 p.m., the following ceiling smoke barriers were not fire stopped;</p> <p>a. The maintenance office ceiling had a three inch ceiling penetration on the east side of the ceiling above the desk fire stopped with expandable foam. Based on an interview with the maintenance</p>	K010025	<p>K025 1-No facility occupants were harmed. All areas noted in the survey that were lacking firestopping material (the maintenance office ceiling, the kitchen bathroom and dishwashing room) have been repaired with appropriate fire rated supplies (fire rated caulk, etc...). 2-All facility occupants are at risk. All areas noted in the survey that were lacking firestopping material (the maintenance office ceiling, the kitchen bathroom and dishwashing room) have been repaired with appropriate fire rated supplies (fire rated caulk, etc...). 3-All areas noted in the survey that were lacking firestopping material (the maintenance office ceiling, the kitchen bathroom and dishwashing room) have been repaired with appropriate fire rated supplies (fire rated caulk, etc...). Any time construction performed or new wiring installed,</p>	06/21/2013			

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	<p>supervisor on 06/18/13 at 10:10 a.m., the expandable foam does not have a fire rating. Furthermore, there were two, one inch circular areas next to the expandable foam which were not firestopped and four, half inch computer cable penetration on the west side of the ceiling with no firestopping material.</p> <p>b. The kitchen bathroom had a four inch sprinkler pipe ceiling penetration with a two inch gap around the drywall which was not firestopped and the dishwashing room had a half inch gap around a computer cable with no firestopping. The maintenance office ceiling and kitchen ceiling not being firestopped was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the exit conference on 06/18/13 at 1:20 p.m.</p> <p>3.1-19(b)</p>		<p>Maintenance Director or designee will ensure holes will be properly sealed with fire rated supplies.</p> <p>4-Maintenance Director or designee will conduct Preventative Maintenance Program routine rounds. Areas noted to lack proper firestopping materials will be fixed. All findings will be included in the facility's Continuous Quality Improvement program and the plan of action adjusted accordingly when 100% compliance is not achieved.</p>		

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K010046 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 1 of 1 battery backup lights was tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. 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. In addition, NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect any residents during periods of power outages.</p> <p>Findings include:</p> <p>Based on record review on 06/18/13 at 10:15 a.m. with the maintenance</p>	K010046	<p>K046 1-No facility occupants were harmed. Emergency lighting was tested for 90 minutes with results documented and no concerns noted. 2-All facility occupants are at risk. Emergency lighting was tested for 90 minutes with results documented and no concerns noted. 3- Maintenance Director or designee will test the emergency lighting located in the generator area for 30 minutes monthly and annually for 90 minutes with results documented on the Emergency Lighting Log. ED to review log monthly. 4-Preventative maintenance program monitored through the Continuous Quality Improvement program. All findings will be included in the facility's CQI program and the plan of action adjusted accordingly when 100% compliance is not achieved.</p>	06/21/2013			

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	<p>supervisor, the Emergency Lighting Log, which was located in the Preventive Maintenance Log, was reviewed. The monthly and annual testing blocks on the form were blank and failed to indicate a monthly test and annual ninety minute test was conducted on the outside emergency generator battery backup light over the past year. This was verified by the maintenance supervisor at the time of record review and confirmed by the administrator at the exit conference on 06/18/13 at 1:20 p.m.</p> <p>3.1-19(b)</p>			

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K010052 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure the fire alarm system was tested monthly by the transmission of the fire alarm signal during 2 of 12 fire drills conducted over the past year. NFPA 72, National Fire Alarm Code, in Table 7-3.2, Testing Frequencies at number 23 requires monthly testing of the Supervisory Station Fire Alarm Systems receivers. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of Monthly Fire Drill Reports with the maintenance supervisor on 06/18/13 at 9:55 a.m., the fire drills conducted on 09/18/12 at 3:30 a.m. and 03/29/13 at 12:00 a.m. lacked documentation the fire alarm system was activated during each fire drill. Based on an interview with the maintenance supervisor on 06/18/13 at 10:15 a.m., it was indicated the fire alarm system was not tested during these monthly fire drills. The lack of fire alarm system</p>	K010052	<p>K052</p> <p>1-No facility occupants were harmed. The fire alarm system was successfully tested, including the transmission of a fire alarm signal.</p> <p>2-All facility occupants are at risk. The fire alarm system was successfully tested, including the transmission of a fire alarm signal.</p> <p>3-The fire alarm system was successfully tested, including the transmission of a fire alarm signal. Results of fire drill will be documented on monthly fire drill log.</p> <p>4-The Maintenance Director or designee will conduct quarterly fire drills on each shift per the facility preventative maintenance program. Fire drills conducted on third shift will test the fire alarm signal during the day time work hours after the third shift fire drill. All findings will be included in the facility's Continuous Quality Improvement program and the plan of action adjusted accordingly when 100% compliance is not achieved.</p>	07/01/2013			

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	<p>transmission during fire drills was confirmed by the administrator at the exit conference on 06/18/13 at 1:20 p.m.</p> <p>3.1-19(b)</p>			

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K010056 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 97 rooms were sprinklered. This deficient practice could affect 19 residents who reside on the 40 Hall, which is where the water softener room is located.</p> <p>Findings include:</p> <p>Based on observation on 06/18/13 at 12:40 p.m. with the maintenance supervisor, the water softener room was not provided with sprinkler coverage. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 06/18/13 at 1:20 p.m.</p> <p>3.1-19(b)</p>	K010056	<p>K056 1-No facility occupants were harmed. The water softener room will be provided with sprinkler coverage by P.I.P.E., INC. 2-All facility occupants are at risk. The water softener room will be provided with sprinkler coverage by P.I.P.E., INC. 3-The water softener room will be provided with sprinkler coverage by P.I.P.E., INC. 4-The sprinkler system is monitored through the preventative maintenance program. All findings are included in the facility's Continuous Quality Improvement program and the plan of action adjusted accordingly when 100% compliance is not achieved.</p>	07/18/2013

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K010074 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 2 of 45 residents' rooms were flame retardant. This deficient practice could affect 4 resident who reside in resident rooms 7 and 13.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor during a tour of the Front Hall on 06/18/13 from 11:30 a.m. to 12:15 p.m., resident room seven and resident room thirteen each had a window curtain which lacked attached documentation they were inherently flame retardant. Based on interview at the time</p>	K010074	<p>K074</p> <p>1-No facility occupants were harmed. Flame Stop flame retardant was used to treat the window treatments in room 7 and 13.</p> <p>2-All facility occupants are at risk. . Flame Stop flame retardant was used to treat the window treatments in room 7 and 13. All facility window treatments were checked for their fire rating with no concerns noted.</p> <p>3-Flame Stop flame retardant was used to treat the window treatments in rooms 7 and 13. Any new window treatments will be checked for fire rating prior to installation by the Maintenance Director or designee with Flame Stop flame retardant applied</p>	07/12/2013

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	of observations with the maintenance supervisor, there was no documentation regarding flame retardance for window curtains in resident rooms seven and thirteen available for review. This was confirmed by the administrator at the exit conference on 06/18/13 at 1:20 p.m.  3.1-19(b)		when necessary. 4-Maintenance Director or designee will follow Preventative Maintenance Program regarding fire rated window treatments. All findings will be included in the facility's Continuous Quality Improvement program and the plan of action adjusted accordingly when 100% compliance is not achieved.				

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K010130 SS=F	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 45 of 45 resident rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on an interview on 06/18/13 at 10:45 a.m. with maintenance supervisor during record review, the facility has forty five resident rooms with forty five battery operated smoke detectors located in each of the resident rooms. Furthermore, there was no preventive maintenance program to document monthly testing and annual battery replacement for each battery operated smoke detector. The lack of a written maintenance program to provide monthly testing and annual battery replacement for the forty five resident room battery operated smoke detectors was verified by the maintenance supervisor at the time of interview and confirmed by the administrator at the exit conference on 06/18/13 at 1:20 p.m.</p>	K010130	<p>K130 1-No facility occupants were harmed. All facility battery operated smoke detectors have been tested and all are in good working order with results documented on log. 2-All facility occupants are at risk. All facility battery operated smoke detectors have been tested and all are in good working order with results documented on log. 3-All facility battery operated smoke detectors have been tested and all are in good working order with results documented on log. 4-The Maintenance Director or designee will test battery operated smoke detectors monthly and the ED will review the battery log to ensure complete. All findings will be included in the facility's Continuous Quality Improvement program and the plan of action adjusted accordingly when 100% compliance is not achieved.</p>	06/28/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	<input checked="" type="checkbox"/> (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155697	<input checked="" type="checkbox"/> (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 _____ B. WING _____	<input checked="" type="checkbox"/> (X3) DATE SURVEY COMPLETED  06/18/2013
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	3.1-19(b)			