

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155699	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/23/2015
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NAME OF PROVIDER OR SUPPLIER BRIDGEWATER REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 715 N MILL ST HARTFORD CITY, IN 47348
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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: 03/23/15</p> <p>Facility Number: 000290 Provider Number: 155699 AIM Number: 100379970</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Bridgewater Rehabilitation Centre 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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors</p>	K 000	<p>Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report.</p> <p>Submission of this Plan of Correction Does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>This Plan of Correction is prepared and submitted because of requirements under State and Federal law.</p> <p>Please accept this Plan of Correction As our credible allegation of Compliance.</p>	

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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K 038 SS=E Bldg. 01	<p>and hard wired smoke detection in 15 resident rooms on 200 hall and battery powered smoke alarms in 25 resident rooms on 100 hall. The facility has a capacity of 78 and had a census of 44 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/25/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure exit access was arranged so 1 of 7 exits was readily accessible at all time. LSC Section 7.1.6.3 states walking surfaces shall be nominally level. The slope of a walking surface in the direction of travel shall not</p>	K 038	<p>1.Ahandrail has been added to the 100 hall west exit discharge ramp. The ramp hasbeen repaired to even out the drop.</p> <p>2.No residents were affected by this alleged negative practice.</p> <p>3.TheMaintenance Director has been re-educated on monitoring</p>	04/22/2015

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K 144 SS=F Bldg. 01	<p>exceed 1 in 20 inches. LSC Section 7.2.2.4.2 requires handrails shall be provided along both sides of a ramp. LSC Section 7.2.2.4.2 Exception #3 requires that an existing ramp shall have a handrail on at least one side. This deficient practice could affect 18 residents on 100 west hall if it was necessary to use the ramp exit to evacuate the building as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 03/23/15 at 1:45 p.m., with the Maintenance Supervisor the 100 hall west exit discharge ramp lacked handrails. The cement ramp was four feet wide by four feet long and was measured with the Maintenance Supervisor to have a slope of a two inch drop to nine inches of walkway. Based on interview on 03/23/15 during the measurement at 1:50 p.m. with the Maintenance Supervisor it was confirmed the slope measurement was accurate and no handrails were provided.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and</p>		<p>the exit door ramps to ensure uneven surfaces have not occurred due to settling of ground. Exit door monitoring has been added to the monthly preventative maintenance schedule (See Attachment A).</p> <p>4. The Maintenance Director/Designee will review exit door ramps monthly. Should concern be found, immediate action will occur. These reviews will be discussed during the facilities quarterly QA meetings on an ongoing basis and the plan adjusted if indicated.</p>	

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	<p>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 monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions; at not less than 30% of the Emergency Power Supply (EPS) nameplate rating; or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents as well as staff and visitors.</p>	K 144	<p>1.Theconversion formula has been added to the generator monthly load test log sheet.</p> <p>2.No residents were affected by this alleged negative practice.</p> <p>3.TheMaintenance Director has been re-educated on proper documentation on themonthly generator load and over the conversion formula. The conversion formulahas been added to the generator monthly load test log sheet (See Attachment B).</p> <p>4.TheMaintenance Director/Designee will document properly on the monthly generatorlog to ensure load capacity is within normal range. Should concern be found,immediate action will occur. These reviews will be discussed during thefacilities quarterly QA meetings on an ongoing basis and the plan adjusted ifindicted.</p>	04/22/2015

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	<p>Findings include:</p> <p>Based on review of Generator System Testing records and Maintenance logs on 03/23/15 at 2:44 p.m. with the Maintenance Supervisor, the amperage during load could not be verified to be at least thirty percent of the EPS nameplate rating and no other method was used to document monthly load for the past twelve months. Based on interview on 03/23/15 concurrent with record review with the Maintenance Supervisor, it was acknowledged the facility had been running the generator monthly but lacked documentation the load was at least 30 percent of the nameplate rating and no other equivalent method was used to comply with percentage of load capacity for the past twelve months.</p> <p>3.1-19(b)</p>			