

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155532	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2012
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NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
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: 03/22/12</p> <p>Facility Number: 000460 Provider Number: 155532 AIM Number: 100290620</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Bloomington 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 one story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors with no smoke detectors in the resident</p>	K0000		

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>rooms. The facility has a capacity of 38 and had a census of 29 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/27/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0038 SS=E	<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 1 exit access doors for the kitchen was not equipped with 2 locking devices on the doors. Section 19.2.2.2.5 requires means of egress are permitted to be locked, but only one locking device shall be permitted on each door. This deficient practice could affect 10 residents on west hall as well as visitors and staff in the facility.</p> <p>Findings include:</p> <p>Based on observation on 03/22/11 at 12:22 p.m. with the Maintenance Supervisor, the door leading out of the kitchen on west hall had a door knob lock and a deadbolt lock on the door. Based on interview on 03/22/12 at 12:24 p.m. with the Maintenance Supervisor, it was acknowledged there were two locking devices on the kitchen door which could require the unlocking of a door knob lock and a deadbolt to exit the kitchen.</p> <p>3.1-19(b)</p>	K0038	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K 038 Egresses</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: The deadbolt has been removed and a escutcheon cover has been placed over the hole in the door.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Any resident, visitor, employee or vendor has the potential to be affected, but none were identified.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: The importance of this regulation has been reviewed with the Director of maintenance and during his daily rounds he will assure that this is followed and that no door shall have more than one (1) Locking mechanism at anytime.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be</p>	04/21/2012			

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			<p>put into place: The monitoring of this will be a joint effort between the NHA/ Director of Maintenance/MOD as they make their weekly facility rounds which will include a visual check of all doors to assure that there is no more than one(1) locking mechanism per door at anytime. This will be an on going plan of correction. A report of the findings will be presented at the risk management/QA meeting for review.</p> <p>(e) Date of compliance: 4/21/12</p>		