

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2016
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NAME OF PROVIDER OR SUPPLIER  CYPRESS GROVE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630
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K 0000  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: 09/16/16</p> <p>Facility Number: 000173 Provider Number: 155273 AIM Number: 100290920</p> <p>At this Life Safety Code survey, Cypress Grove 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) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 90 and had a census of 79 at the time of this</p>	K 0000	<p><b>Plan of Correction for Cypress Grove Rehabilitation Center 2016 Annual Life Safety Survey</b></p> <p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of the Post Survey Revisit on October 16, 2016</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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K 0018 SS=E Bldg. 01	<p>survey.</p> <p>All areas where the residents have customary access were sprinklered.</p> <p>There were four, eight foot by twelve foot, and one, twelve foot by sixteen foot wood framed portable sheds located outside the east unit east exit and filled with activity storage, Central Supply storage, Dietary storage, and Therapy storage, which were not sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist on 09/20/16</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities.</p>			

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	<p>19.3.6.3 Based on observation and interview, the facility failed to ensure 1 of over 1 Living Moments corridor dining room doors would resist the passage of smoke. This deficient practice could affect at least 10 residents, staff and visitors in the vicinity of the Living Moments Dining room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:00 a.m. to 1:30 p.m. on 09/16/16, two separate pencil sized holes, one above and one below the door handle were noted in the corridor door to the Living Moments Dining room. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned corridor door would not resist the passage of smoke.</p> <p>3.1-19(b)</p>	K 0018	<p><b>K 018</b></p> <p><b>1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>The pencil sized holes above and below the door handle on the corridor door to the Living Moments Dining Room has been repaired to resist the passage of smoke.</p> <p><b>1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>Residents that reside on both sides of the Living Moments Dining Room door have the potential to be affected by the alleged deficient practice. An audit was completed to ensure all corridor doors are free of holes and resistant to the passage of smoke. The doors were repaired as indicated by the audit.</p> <p><b>1.What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>Director of Maintenance has been in-serviced by the Executive Director (ED)/designee on maintaining</p>	10/07/2016	

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K 0025 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated		<p>corridor doors that resist the passage of smoke. The maintenance director will report all work orders and repairs related to corridor doors to the Executive Director. An inspection will be completed by the Maintenance Director/designee after all related work is completed to ensure the doors are resistance to passage of smoke.</p> <p><b>1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., quality assurance program will be put into place?</b></p> <p>To ensure continued compliance, the inspections will be reviewed by the ED/ designee weekly X 6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance.</p> <p><b>Date of compliance:</b> October, 7 2016</p>		

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	<p>glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 5 of 7 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect all residents, staff and visitors throughout the facility.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:00 a.m. to 1:30 p.m. on 09/16/16, the following was noted:</p> <p>a) The E Hall attic had one exposed penetration through the smoke barrier that was not firestopped. The unprotected penetration was where a bundle of gray, blue and white cables penetrated the smoke barrier and had a 1/2 inch gap.</p> <p>b) The D Hall attic had two exposed</p>	K 0025	<p>K 025</p> <p><b>1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>The smoke barriers in E, D, F, H, and A hall attics were repaired to ensure that they are resistant to the passage of smoke.</p> <p><b>1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>All residents, staff, and visitors had the potential to be affected by the alleged deficient practice. An audit was completed to identify passages in smoke barriers that allow the passage of smoke. Repairs were made as indicated by the audit.</p> <p><b>1.What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>The Director of Maintenance has been in-serviced by the ED/designee on maintaining attic smoke barriers to ensure the protection against the</p>	10/07/2016

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K 0050 SS=C Bldg. 01	<p>penetrations through the smoke barrier that were not firestopped. One was a 2 inch by 3 inch unprotected penetration beneath a sprinkler pipe and the other was a penetration where a bundle of gray, blue and white cables penetrated the smoke barrier with a ½ inch gap.</p> <p>c) The F Hall attic had one exposed 12 inch by 12 inch opening through the smoke barrier that was not firestopped.</p> <p>d) The H Hall attic had one exposed 2 foot by 2 foot opening through the smoke barrier that was not firestopped.</p> <p>e) The A Hall attic had six exposed penetrations through the smoke barrier that were not firestopped. The six penetrations were all pipe sleeves with penetrating cables with 1 inch gaps. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned penetrations did not ensure the smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that</p>				<p>passage of smoke. Smoke barriers will be inspected after any maintenance work is completed in the attic to ensure they protect against the passage of smoke.</p> <p><b>1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., quality assurance program will be put into place?</b></p> <p>To ensure compliance, the inspections will be reviewed by the ED/designee weekly X 6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance.</p> <p><b>1.Date of compliance:</b> October, 7 2016</p>		

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	<p>drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were held under varied conditions for 11 of 12 fire drills. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills on 09/16/16 at 9:55 a.m. with the Maintenance Supervisor, the " Monthly Fire Drill " report form indicated to stagger times, conditions and areas for each drill. The 1st entry on the form asked to " Describe Simulated Situation ". For eleven of the twelve fire drills completed for the past year, the described simulated situation was either " walk thru " or " fire drill ". Based on interview at the time of record review, the Maintenance Supervisor acknowledged the descriptions and agreed the descriptions of the simulation were not varied.</p> <p>3-1.19(b)</p>	K 0050	<p><b>K 050</b></p> <p><b>1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Fire drills are held under varied simulated conditions.</p> <p><b>1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>All residents, staff, and visitors had the potential to be affected by the alleged deficient practice. Fire drills are held under varied simulated conditions..</p> <p><b>1.What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>The Director of Maintenance has been in-serviced by the ED/designee on varying the simulated conditions of fire drills. The ED will review the</p>	10/07/2016			

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K 0056 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations		<p>monthly fire drill schedule to ensure simulated conditions are varying.</p> <p><b>1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., quality assurance program will be put into place?</b></p> <p>To ensure continued compliance, the ED/designee will review the completed "Monthly Fire Drill" report during the Monthly Safety Committee Meeting for 6 months to ensure the simulated conditions of fire drills vary. Safety Meeting minutes will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance.</p> <p><b>1.Date of compliance:</b> October, 7 2016</p>		

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	<p>prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 sprinklers in the beauty shop was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Table 5-6.5.1.2 states that distance between a sprinkler head an obstruction less than 1 foot away cannot be lower than the sprinkler head deflector. This deficient practice could affect staff and at least 2 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:00 a.m. to 1:30 p.m. on 09/16/16, a ceiling fan was located directly below the sprinkler head in the beauty shop. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the abovementioned condition.</p> <p>3.1-19(b)</p>	K 0056	<p><b>K 056</b></p> <p><b>1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>The ceiling fan was removed in the beauty shop to ensure the sprinkler head spray pattern is unobstructed.</p> <p><b>1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>The alleged deficient practice had the potential to affect the beauticians and 2 residents. An audit was completed to ensure sprinkler heads are free of any objects that could obstruct their spray pattern. All sprinkler heads are free of objects that would obstruct their spray pattern.</p> <p><b>1.What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>The Director of Maintenance has been in-serviced by the ED/designee on maintaining sprinkler heads that are free of obstructions. The ED or</p>	10/07/2016			

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K 0072 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1		<p>Maintenance Director/designee will review all potential change to the physical plant to ensure sprinkler heads remain free of obstructions. The Maintenance Director/designee will inspect all changes made to the physical plant to ensure all sprinkler heads remain free of obstructions.</p> <p><b>1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., quality assurance program will be put into place?</b></p> <p>To ensure compliance, the ED/Designee will review maintenance inspections weekly X 6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee and overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. <b>Date of compliance:</b> October, 7 2016</p>	

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	<p>Based on observation and interview, the facility failed to ensure the means of egress through 2 of 3 Living Moments exits met all conditions of LSC 7.1.9 so it would be readily accessible for all residents, staff and visitors. LSC 7.1.9 states any device or alarm installed to restrict the improper use of a means of egress shall be designed and installed so that it cannot, even in the case of failure, impede or prevent emergency use of such means of egress. This deficient practice could affect all residents as well as staff and visitors in the Living Moments Unit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:00 a.m. to 1:30 p.m. on 09/16/16, all three of the Living Moments Unit exit doors were provided with a sign stating "Push the door until alarm sounds. Door will open in fifteen seconds", however, the north and south exit doors failed to open when pressure was applied after 15 seconds. Based on interview at the time of observation, the Maintenance Supervisor was unsure if the Living Moments Unit exits were set up for delayed egress.</p> <p>3.1-19(b)</p>	K 0072	<p><b>K 072</b></p> <p><b>1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>The signs on the two doors of the Living Moments Unit that stated "Push until door alarm sounds. Door will open in fifteen seconds" were removed.</p> <p><b>1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>The alleged deficient practice had the potential to affect residents, staff, and visitors on the Living Moments Unit. An audit was completed to ensure no other "Push until door alarm sounds. Door will open in fifteen seconds" signs were in place if a 15 second egress was not set up on the identified door. Signs were removed as indicated by the audit.</p> <p><b>1.What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>The Director of Maintenance has been in-serviced by the ED/designee</p>	10/07/2016			

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K 0130 SS=E Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786  Based observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors were in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or	K 0130	<p>on proper door signage related to 15 second egress. All new signage will be reviewed and approved by the ED/designee prior to being placed on a door to ensure proper usage of each sign.</p> <p><b>1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., quality assurance program will be put into place?</b></p> <p>To ensure compliance, all new signage will be reviewed during the Monthly Safety Committee Meeting for 6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance.</p> <p><b>1.Date of compliance:</b> October, 7 2016</p> <p><b>1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient</b></p>	10/07/2016

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NAME OF PROVIDER OR SUPPLIER  CYPRESS GROVE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630
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(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
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	<p>system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 8 residents on Meadows north as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 09/16/16 at 11:00 a.m. with the Maintenance Supervisor, there was one metal rolling fire door protecting the opening from the kitchen to the Main dining room with an inspection tag dated 07/14/15. Based on interview at the time of observation, the Maintenance Supervisor acknowledged there was no additional or more current documentation of an annual inspection or test to check for proper operation and full closure of the metal curtain.</p>		<p><b>practice?</b></p> <p>The rolling kitchen fire door was inspected and tested. The annual test ensured proper operation and full closure of the rolling fire door.</p> <p><b>1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>The alleged deficient practice had the potential to affect residents and visitor in the dining room. The kitchen rolling fire door is the only rolling fire door in the facility.</p> <p><b>1.What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>The Director of Maintenance has been in-serviced by the ED/designee on the requirement of an annual inspection and testing of the rolling fire door.</p> <p><b>1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., quality assurance program will be put into place?</b></p> <p>To ensure compliance, the annual inspection and test will be reviewed</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2016
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	3.1-19(b)		<p>during the Monthly Safety Committee Meeting monthly. This practice will be ongoing. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance.</p> <p><b>1.Date of compliance:</b> October, 7 2016</p>	