

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 10/03/2013
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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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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: 10/03/13</p> <p>Facility Number: 000173 Provider Number: 155273 AIM Number: 100290920</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</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 in spaces open to the corridors, plus battery operated smoke detectors in all resident</p>	K010000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.	

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>sleeping rooms. The facility has a capacity of 100 and had a census of 84 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. 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 Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/07/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010038 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 egress for 1 of 11 exits was arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.2 through 7.1.6.4. LSC Section 7.1.6.2 requires abrupt changes in elevation shall not exceed 1/4 inch. LSC Section 7.1.6.3 requires walking surfaces to be nominally level. This deficient practice could affect up to 17 residents, as well as staff and visitors while exiting the D Hall through the north exit door to a public way.</p> <p>Findings include:</p> <p>Based on observation on 10/03/13 at 1:45 p.m. during a tour of the facility with the Maintenance Director, the asphalt surface between the D Hall north exit and the exit gate was cracked and raised three to four inches. Based on interview at the time of observation, the Maintenance Director acknowledged the asphalt surface was raised three to four inches and could be a</p>	K010038	K-038The asphalt surface walkway between the D Hall north exit and the exit gate is scheduled to be removed on November 6, 2013 and replaced with concrete. The tree next to this walkway, whose roots have cracked and raised the asphalt, is scheduled to be removed along with the roots during the week of October 28, 2013. Due to the size of this tree and roots, equipment will have to be brought in by the paving company to remove the tree and the roots, thus delaying the new concrete being poured until November 6th. A signed purchase order for this work is included as an attachment to the Plan of Correction. We would ask for an extension of the compliance date to allow for this work to be completed.	11/06/2013			

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	tripping hazard. 3.1-19(b)			

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K010052 SS=F	<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 8 of 53 smoke detectors had been tested for sensitivity. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <p>(1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for</p>	K010052	K-052All smoke detectors were sensitivity tested on October 16, 2013. All 53 smoke detectors in the facility passed sensitivity testing. The documentation of the sensitivity tests, including the results, from Vanguard Alarm Services is included as an attachment to the Plan of Correction.	10/16/2013			

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	<p>the purpose.</p> <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range.</p> <p>(5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires inspection, testing and maintenance reports be provided for the owner or a designated representative. It shall be the responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having jurisdiction. Paper or electronic media shall be acceptable. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the smoke detector sensitivity records in the Maintenance Manual on 10/03/13 at 10:45 a.m. with</p>			

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	<p>the Maintenance Director present, the most recent sensitivity test documentation available was dated 07/13/12 for fifty three smoke detectors where eight smoke detectors failed the sensitivity test. The facility was not able to produce documentation to show when the eight smoke detectors were replaced and when retesting for sensitivity was performed. Based on interview at the time of record review, the Maintenance Director stated the eight smoke detectors were replaced, but have not been retested for sensitivity.</p> <p>3.1-19(b)</p>			