STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 01 B. WING	06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	140 W WASHINGTON ST MORGANTOWN, IN 46160

(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
K 0000 Bldg. 01	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). Survey Date: 06/06/17 Facility Number: 000399 Provider Number: 15E683 AIM Number: 100289100 At this Life Safety Code survey, Morgantown Health Care was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a basement was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 39 and had	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	a census of 35 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing storage services which was not sprinklered. Quality Review completed on 06/07/17 - DA			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 3 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 20 residents, staff and visitors near the main entrance. Findings include: Based on observations with the Environmental Manager and the Maintenance Director during a tour of the facility from 10:50 a.m. to 11:30 a.m. on	K 0211	K-211 1. FURNITURE WAS REMOVED FROM CORRIDER ACROSS FROM THE MAIN ENTRANCE DOOR AND HUTCH OPPOSITE SIDE OF CORRIDER BY THE ADMINISTRATORS OFFICE WAS REMOVED. 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. 3. FURNITURE IN MAIN CORRIDOR WILL NOT BE REPLACED SO THAT THERE IS PROPER EGRESS IN CASE OF AN EMERGENCY OR FIRE. AREA WAS A SEATING	07/06/2017

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	06/06/17, two chairs and one wooden table were stored in the corridor across from the main entrance door each projecting two feet into the corridor. In addition, a wooden hutch was stored on the opposite side of the corridor outside the Administrator's Office which projected eighteen inches into the corridor. Based on interview at the time of observations, the Environmental Manager acknowledged the aforementioned means of egress was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 3.1-19(b)		ARRANGEMENT FOR RESIDENTS AND VISISTORS, NOT A STORAGE AREA. 4. HFA, ENVIROMENTAL SUPERVISOR WILL MONITOR DAILY. THE QA COMMITTEE WILL REVIEW FOR 6 MONTHS. THE FACILITY WILL FOLLOW THE RECOMMENDATIONS OF THE QA COMMITTEE. 5. DATE COMPLETED: JULY 6, 2017	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width	K 0232	K-232 1. FURNITURE WAS	07/06/2017

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	requirement for 1 of 3 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected		REMOVED FROM CORRIDER ACROSS FROM THE MAIN ENTRANCE DOOR AND HUTCH OPPOSITE SIDE OF CORRIDER BY THE ADMINISTRATORS OFFICE WAS REMOVED. 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. 3. FURNITURE IN MAIN CORRIDOR WILL NOT BE REPLACED SO THAT THERE IS PROPER EGRESS IN CASE OF AN EMERGENCY OR FIRE. AREA WAS A SEATING ARRANGEMENT FOR RESIDENTS AND VISITORS, NOT A STORAGE AREA. 4. HFA, ENVIROMENTAL SUPERVISOR WILL MONITOR DAILY. THE QA COMMITTEE WILL REVIEW FOR 6 MONTHS. THE FACILITY WILL FOLLOW THE RECOMMENDATIONS OF THE QA COMMITTEE. 5. DATE COMPLETED: JULY 6, 2017	

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	throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect 20 residents, staff and visitors near the main entrance. Findings include: Based on observations with the Environmental Manager and the Maintenance Director during a tour of the facility from 10:50 a.m. to 11:30 a.m. on 06/06/17, two chairs and one wooden table were stored in the corridor across from the main entrance door each projecting two feet into the corridor which were each not affixed to the floor or to the wall. In addition, a wooden hutch was stored on the opposite side of the corridor outside the Administrator's Office which projected eighteen inches into the corridor and was also not affixed to the floor or to the wall. Based on interview at the time of the observations, the Environmental Manager acknowledged furniture was stored in the aforementioned eight foot wide corridor which was not affixed to the floor or to the wall. 3.1-19(b)			

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K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required	K 0711	K-711 1. PLAN OF CORRECTION FOR WHEELED EQUIPMENT WAS WRITTEN JUNE 6, 2017 SO THAT PROPER EGRESS WAS ESTABLISHED FOR HALLWAYS IN CASE OF EMERGENCY OR FIRE IN MORGANTOWN HEALTH CARE. 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. 3. STAFF WAS IN SERVICED ON JUNE 15, 2017 ON PROPER EGRESS FOR HALLWAYS IN CASE OF AN EMERGENCY OR FIRE. 4. HFA, DON OR DESGNEE, SSD, EVIROMENTAL SUPERVISOR, MAINTENCANCE, AND STAFF WILL MONITOR DAILY. QA	07/06/2017

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	aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Preparedness Plan" and "Fire Plan" documentation with the Environmental Manager and the Maintenance Director during record review from 9:20 a.m. to 10:50 a.m. on 06/06/17, the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on interview at the time of record review, the Environmental Manager acknowledged the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar		WILL REVIEW FOR 6 MONTHS. THE FACILITY WILL FOLLOW THE RECOMMENDATIONS OF THE QA COMMITTEE. 5. DATE COMPLETED: JULY 6, 2017.	

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	emergency. Based on observations with the Environmental Manager and the Maintenance Director during a tour of the facility from 10:50 a.m. to 11:30 a.m. on 06/06/17, four crash carts were noted in the corridor by the nurse's station and a linen cart in use was also in the corridor outside Room 17. 3.1-19(b)			