STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155133	A. BUILDING -- B. WING	08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELMONT HEALTH & REHABILITATION, THE	540 BELMONT DRIVE COLUMBUS, IN 47201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/21/23 Facility Number: 000058 Provider Number: 155133 AIM Number: 100283340 At this Emergency Preparedness survey, The Belmont Health and Rehabilitation was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 180 certified beds. At the time of the survey, the census was 101. Quality Review completed on 08/22/23	E 0000	Submission of this plan of correction does not constitute admissions or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).	K 0000	Submission of this plan of correction does not constitute admissions or agreement by the provider of the truth of facts alleged or correction set forth on	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tyler Reed	Administrator	09/01/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Survey Date: 08/21/23 Facility Number: 000058 Provider Number: 155133 AIM Number: 100283340 At this Life Safety Code survey, The Belmont Health and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and with 410 IAC 16.2. This one story facility 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 in all areas open to the corridor. The facility has smoke detectors hard wired to the building electrical system with battery backup installed in all resident sleeping rooms. The facility has a capacity of 180 and had a census of 101 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered including the detached laundry building. The facility has one detached oxygen storage shed which was not sprinklered. Quality Review completed on 08/22/23		the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program			

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	complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm System Record of Completion" documentation dated 12/05/22 with the Maintenance Director during record review from 9:10 a.m. to 12:35 p.m. on 08/21/23, semi-annual fire alarm system inspection documentation six months after 12/05/22 was not available for review. Based on interview at the time of record review, the Maintenance Director agreed semi-annual inspection documentation for the facility's fire alarm system six months after	K 0345	1. No residents, staff, or visitors were affected. 2. All residents, staff, and visitors have the potential to be affected, thus the following corrective actions have been taken; 3. The Maintenance Director completed visual semi-annual fire alarm system inspection to ensure the following are in proper working order: control unit trouble signals, remote annunciators , initiating devices, notification appliances, and magnetic hold-open devices (Attachment A) 4. The Maintenance Director and Administrator will ensure visual semi-annual fire alarm system inspection is completed and documented no later than 6 months after previous inspection. Maintenance Director educated on regulation (Attachment B) 5. Corrective action will be completed on or before September 1, 2023.	09/01/2023

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	12/05/22 was not available for review. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation and interview; the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC Section 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 0353	1. No residents, staff, or visitors were affected. 2. All residents, staff, and visitors have the potential to be affected, thus the following corrective actions have been taken; 3. The Maintenance Director got written confirmation from Johnson Controls that they will inspect sprinkler system	09/01/2023

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	Water-Based Fire Protection Systems. NFPA 25, Section 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. Section 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, Section 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, Section 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. NFPA 25, Section 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Sprinkler Inspection Report" documentation dated 04/03/23 and 08/10/23 with the Maintenance Director during record review from 9:10 a.m. to 12:35 p.m. on 08/21/23, it had been greater than 90 days in between the second and third quarter sprinkler inspections in calendar year 2023. Review of the aforementioned sprinkler system inspection documentation indicated it had been a total of 129 days in between the two most recent sprinkler system inspections. Based on interview at the time of record review, the Maintenance Director stated additional quarterly sprinkler inspection documentation for the second and third quarters in 2023 was not available for review. Based on observations with the Administrator and the Maintenance Director during a tour of the facility		components every quarter and no later than 90 days from previous inspection (Attachment C). 4. The Maintenance Director and Administrator will ensure sprinkler system inspection is completed and documented every quarter and no later than 90 days from previous inspection. Maintenance Director educated on regulation (Attachment D). 5. Corrective Action will be completed on or before September 1, 2023.	

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	from 12:50 p.m. to 3:15 p.m. on 08/21/23, the sprinkler system inspection contractor had affixed hanging tags to sprinkler system riser locations documenting sprinkler system inspections occurred on 01/19/23, 04/03/23 and on 08/10/23. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0930 SS=A Bldg. 01	NFPA 101 Gas Equipment - Liquid Oxygen Equipment Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) Based on observation and interview, the facility failed to protect 3 of over 50 resident rooms from the use of liquid oxygen containers stored in a patient bed location or patient care room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.7.4 states the maximum total quantity of liquid oxygen permitted in storage and in use in a patient bed location or patient care room shall be 120 L (31.6 gallons), provided that the patient bed location or patient care room, or both, are separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour in accordance with the adopted building code. Per Centers for Medicare & Medicaid Services (CMS), this practice is deficient according to NFPA 99, 2012 Edition, Section 11.7.4, but NFPA has released a Tentative Interim Amendment (TIA) for that section and CMS will be issuing further guidance on that code section. LSC Section	K 0930	1. No residents, staff, or visitors were affected. 2. All residents, staff, and visitors have the potential to be affected, thus the following corrective actions have been taken; 3. The Administrator ordered high flow concentrators to be used in place of liquid oxygen containers for residents requiring them. Liquid oxygen containers have been removed from resident rooms and back outside to our oxygen storage area. 4. The Maintenance Director and Administrator or designee will ensure resident rooms do not have liquid oxygen containers in their rooms by completing 5 room	09/01/2023

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	7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. This deficient practice could affect 3 residents, staff and visitors. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:15 p.m. on 08/21/23, one liquid oxygen container was stored in resident sleeping Room 407, in resident sleeping Room 706 and in resident sleeping Room 800. Each of the three resident sleeping rooms was not separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour. The corridor door to the room was not self-closing or automatic closing and was not equipped with a minimum 45-minute fire resistance rating label affixed to the door. Based on interview at the time of the observations, the Maintenance Director agreed a liquid oxygen container was stored in each of the three resident sleeping rooms and the rooms were not maintained with a minimum fire resistance rating of 1 hour. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		rounds weekly for 4 weeks, then 3 room rounds weekly for 4 weeks, then 1 room round weekly thereafter (Attachment E). Maintenance Director educated on regulation (Attachment F). 5. Corrective action will be completed on or before September 1, 2023.	