| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155807 | A. BUILDING -- B. WING | 01/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| RURAL HEALTH CARE CENTER | 1747 N RURAL ST INDIANAPOLIS, IN 46218 |

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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 01/22/24<br><br>Facility Number: 000388<br>Provider Number: 155807<br>AIM Number: 100454140<br><br>At this Emergency Preparedness survey, Rural Health Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 50 certified beds. At the time of the survey, the census was 30.<br><br>Quality Review completed on 01/24/24 | E 0000 | | |
| K 0000<br><br>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).<br><br>Survey Date: 01/22/24<br><br>Facility Number: 000388<br>Provider Number: 155807<br>AIM Number: 100454140<br><br>At this Life Safety Code survey, Rural Health Care Center was found not in compliance with | K 0000 | Please accept this plan of correction as substantial compliance | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Matthew D. Shafer | HFA | 02/05/2024 |

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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| | 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 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>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 smoke detection in the corridors and in 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 50 and had a census of 30 at the time of this visit.<br><br>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except one metallic P.O.D. type metallic storage shed providing facility storage.<br><br>Quality Review completed on 01/24/24 | | | |
| K 0211 SS=E Bldg. 01 | NFPA 101<br>Means of Egress - General<br>Means of Egress - General<br>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.<br>18.2.1, 19.2.1, 7.1.10.1<br>Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 1 of 4 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled | K 0211 | what corrective actions will be accomplished for those residents found to have been affected by the deficient practice ? | 02/05/2024 |

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| | equipment, provided that all of the following conditions are met:<br>(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.)<br>(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.<br>(c) The wheeled equipment is limited to the following:<br>i. Equipment in use and carts in use<br>ii. Medical emergency equipment not in use<br>iii. Patient lift and transport equipment<br>This deficient practice could affect approximately 10 residents, 4 staff and 2 visitors.<br><br>Findings include:<br><br>Based on observations made with the facility Administrator on 01/22/24 at 12:18 p.m. during a tour the facility, there was a small three drawer plastic storage bin with personal protective equipment (P.P.E.) stored in the corridor immediately outside resident room # 4. This bin was not on wheels. Based on interview with the facility Administrator at the time of the observation, he acknowledged the plastic storage bin in the corridor was not on wheels and added that he would find another bin to use as soon as possible that was on wheels.<br><br>3.1-19(b)<br><br>This item was discussed again with the facility Administrator at the exit conference. | | Item was removed from the hallways. The item was an isolation cart that didnt have wheels on it.<br><br>This deficiency has the potential to affect all residents. No residents were affected.<br><br>Daily walk throughs will be done by ED to ensure all means of egress are clear.<br><br>How the corrective actions will be monitored to ensure the defixient practice does not recurr<br><br>Results will be brought to QA. Maint Dir for follow up for 6 months. | |
| K 0293<br>SS=E<br>Bldg. 01 | NFPA 101<br>Exit Signage<br>Exit Signage | | | |

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| | 2012 EXISTING<br>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.<br>19.2.10.1<br>(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)<br>Based on observation and interview, the facility failed to ensure 1 of 1 kitchen service hall door to the outside of the facility was not marked as a facility exit / or not an exit.. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect as many as 5 staff.<br><br>Findings include:<br><br>Based on observations made with the facility Administrator on 01/22/24 at 1:19 p.m. during a tour the facility, the kitchen service hall door to the outside of the facility was not posted with an EXIT sign or a NO EXIT sign. Based on interview at the time of the observations, the facility Administrator stated that he was unsure if this door was or was not an exit to the public way and acknowledged that the aforementioned door did not have an EXIT or NO EXIT sign posted.<br><br>3.1-19(b) | K 0293 | what corrective actions will be accomplished for those residents found to have been affected by the deficient practice ?<br><br>Exit sign was put above exit door.<br><br>This deficiency has the potential to affect all residents. No residents were affected.<br><br>Daily walk throughs will be done by ED to ensure all exit doors have illuminated signage<br><br>How the corrective actions will be monitored to ensure the defixient practice does not recurr<br><br>Results will be brought to QA. Maint Dir for follow up for 6 months. | 02/05/2024 |

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| K 0300<br>SS=F<br>Bldg. 01 | NFPA 101<br>Protection - Other<br>Protection - Other<br>List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br>Based on record review, interview, and observation the facility failed to ensure documentation for the preventative maintenance of 28 of 28 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors.<br><br>Findings include:<br><br>Based on record review on 01/22/24 between 9:30 a.m. and 12:18 p.m. with the facility Administrator, there was no itemized list of resident room battery operated smoke alarms tested for functionality on a monthly basis during the past twelve months. The records presented for review stopped being documented on 10/10/2022. Based on interview at the time of review, the Administrator acknowledged the battery-operated smoke detector manufacturer recommendations called for | K 0300 | what corrective actions will be accomplished for those residents found to have been affected by the deficient practice ?<br><br>Preventative maintenance of all battery operated smoke alarms documentation post life safety code recertification has been maintained for the safety of all residents and will continue to be maintained and tested in accordance with the manufactures published instructions and per requirements of chapter 14.<br>This deficiency has the potential to affect all residents. No residents were affected.<br>Weekly review will be conducted by the maintenance director to ensure that all documentation for the preventative mainetnace of all battery operated smoke alarms in resident rooms is complete and up to date.<br><br>How the corrective actions will be monitored to ensure the defixient practice does not recurr | 02/05/2024 |

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| | monthly testing. Based on observations made during tour of the facility from 12:18 p.m. to 1:42 p.m. between 10:25 p.m. and 12:37 p.m. during a tour of the facility, battery operated smoke alarms were observed in all resident sleeping rooms.<br><br>This item was discussed again with the facility Administrator at the exit conference.<br><br>3.1-19(b) | | Results will be brought to QA. Maint Dir for follow up for 6 months. | |
| K 0345<br>SS=F<br>Bldg. 01 | NFPA 101<br>Fire Alarm System - Testing and Maintenance<br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program 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.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 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:<br>a. Control unit trouble signals<br>b. Remote annunciators<br>c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.)<br>d. Notification appliances | K 0345 | The visual fire alarm testing was completed on Feb.5, 2024.<br><br>All residents , vendors and staff had the potential to be affected by this alleged deficient practice finding.<br><br>A monthly inspection will be added to TELs .<br><br>The administrator and or designee will monitor monthly to ensure ongoing compliance | 02/05/2024 |

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| | e. Magnetic hold-open devices<br>This deficient practice could affect all occupants in the facility.<br><br>Findings include:<br><br>Based on record review on 01/22/24 at 10:38 a.m. with the facility Administrator present, documentation could not be provided regarding a visual semi-annual fire alarm system inspection. The last recorded inspection of the Fire alarm system was completed on 10/10/2023 and was documented as an annual system inspection, but no documentation could be located as far as a semi-annual visual inspection. Based on interview at the time of record review, the facility Administrator agreed that visual semi-annually inspections of the fire-alarm system was not available for review as of the time of this survey.<br><br>3.1-19(b)<br><br>This item was discussed again with the facility Administrator at the exit conference. | | Results of all audits will be submitted to QAPI. The QA performance improvement committee | |
| K 0353<br>SS=F<br>Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>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.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____ | | | |

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| | c) Water system supply source<br><br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>1) Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all occupants in the facility.<br><br>Findings include:<br><br>Based on review of the Integrated Electronics Inc. (I.E.I.) sprinkler system inspection documentation entitled "Form for Inspection, Testing, and Maintenance of wet Pipe Fire Sprinkler System" documentation for the most recent twelve-month period with the facility Administrator during | K 0353 | what corrective actions will be accomplished for those residents found to have been affected by the deficient practice ?<br><br>Preventative maintenance visual inspection was done post life safety code recertification has been maintained for the safety of all residents and will continue to be inspected and documented in accordance with the regulation<br><br>This deficiency has the potential to affect all residents. No residents were affected.<br><br>Visual inspections will be conducted by the maintenance director to ensure that all inspections occur and are documented.<br><br>How the corrective actions will be monitored to ensure they remain in compliance<br><br>Visual Inspection will be done on sprinkler system and documented.<br><br>Results will be brought to QA. Maint Dir for follow up for 6 months. | 02/05/2024 |

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| | record review from 9:30 a.m. to 12:18 p.m. on 01/22/24, the monthly wet sprinkler system gauge inspection documentation was last documented as being completed on June of 2022. In addition, monthly inspection documentation for all sprinkler system control valves for 12 months of the most recent 12-month period was also not available for review with the last documented inspection also being completed on June of 2022. Based on interview at the time of record review, the facility Administrator acknowledged sprinkler system gauge and control valve inspection documentation for the aforementioned monthly periods was not available for review.<br><br>3.1-19(b)<br><br>This item was discussed again with the facility Administrator at the exit conference.<br><br>2) Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect up to 10 residents, 4 staff, and 2 visitors in the facility.<br><br>Findings include:<br><br>Based on observations made with the facility Administrator on 01/22/24 at 1:19 p.m. during a tour the facility, the sprinkler piping resting at the ceiling in the corridor on the wing with resident | | | |

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| | rooms #15 through #22, Physical Therapy and Medical Records had wires hung on and draped over the sprinkler system pipes. Based on an interview at the time of the observation, the facility Administrator agreed that there were wires hung on and draped over the sprinkler system pipes adding that he would have them removed as soon as possible.<br><br>This item was discussed again with the facility Administrator at the exit conference.<br><br>3.1-19(b) | | | |
| K 0355 SS=E Bldg. 01 | NFPA 101<br>Portable Fire Extinguishers<br>Portable Fire Extinguishers<br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br>18.3.5.12, 19.3.5.12, NFPA 10<br>Based on observation and interview, the facility failed to inspect 10 of 10 portable fire extinguishers within the facility. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 says Fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. This deficient practice could affect all residents, staff, and visitors.<br><br>Findings include:<br><br>Based on observations made with the facility Administrator on 01/22/24 at 1:37 p.m. during a tour the facility, the monthly inspection tags on all portable fire extinguishers were not documented as being inspected in December of 2023. This was acknowledged by the facility Administrator at the | K 0355 | what corrective actions will be accomplished for those residents found to have been affected by the deficient practice ?<br><br>All fire extinguishers were inspected to ensure inspections have been done .<br><br>Preventative maintenance of This deficiency has the potential to affect all residents. No residents were affected.<br><br>Weekly review will be conducted by the maintenance director to ensure that all fire extinguishers | 02/05/2024 |

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| | time of each observation who added that the facility had been without a Maintenance man for some time now and he was sure it was just overlooked but he would get them inspected as soon as possible.<br><br>This item was discussed again with the facility Administrator at the exit conference.<br><br>3.1-19(b) | | are charged and initialed .<br><br>How the corrective actions will be monitored to ensure the deficient practice doesn't recurr<br><br>Results will be brought to QA. Maint Dir for follow up for 6 months. | |
| K 0712 SS=F Bldg. 01 | NFPA 101<br>Fire Drills<br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.<br>19.7.1.4 through 19.7.1.7<br>Based on record review and interview, the facility failed to conduct quarterly fire drills for 2 of 4 quarters in 2023. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents.<br><br>Findings include:<br><br>Based on record review of the documentation entitled "Chosen Healthcare Fire Drill Reports" form with the facility Administrator on 01/22/24 between 9:30 a.m. and 12:18 p.m., the following was noted: | K 0712 | What corrective actions will be accomplished for those residents found to have been affected by the deficient practice;<br><br>Facility has maintained documentation of all fire drills and documentation of activation of the fire alarm system for fire drills conducted between 6:00am and 9pm post survey.<br><br>How other residents having the potential to be affected by the | 02/05/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155807 | A. BUILDING 01<br>B. WING | 01/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RURAL HEALTH CARE CENTER | 1747 N RURAL ST<br>INDIANAPOLIS, IN 46218 |

| (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 |
|---|---|---|---|---|
| | a) Documentation of a fire drill conducted on the second shift in the third quarter (July, August, and September) of 2023 was not available for review.<br>b) Documentation of a fire drill conducted on the third shift in the third quarter (July, August, and September) of 2023 was not available for review.<br>c) Documentation of a fire drill conducted on the first shift in the fourth quarter (October, November, and December) of 2023 was not available for review.<br>d) Documentation of a fire drill conducted on the second shift in the fourth quarter (October, November, and December) of 2023 was not available for review.<br>e) Documentation of a fire drill conducted on the third shift in the fourth quarter (October, November, and December) of 2023 was not available for review.<br>Based on interview at the time of record review, the facility Administrator acknowledged the aforementioned missing fore drills adding that the facility was without staff for a time and items were overlooked but he was currently working on getting all testing back on track for the upcoming year.<br><br>This item was discussed again with the facility Administrator at the exit conference.<br><br>3.1-19(b)<br>3.1-51(c) | | same defiecient practice will be identified and what corrective action will be taken.<br><br>What meausre will be put into place and what systematic changes will be made to ensure that the deficient practive does not recur.<br><br>Maintenance Director has been in serviced on fire drill schedule and docuemntation of activation of the fire alarm system for fire drills . Audit of fire drills monitored monthly by maint.<br><br>Results will be rbought to QA by Maintenance director follow up and review for 6 months or until 100% complaince is acheived. | |