

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
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NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
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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: 04/25/13</p> <p>Facility Number: 000569 Provider Number: 155531 AIM Number: 100267660</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Oakbrook Village 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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridor and resident rooms. The facility has a capacity of 55 and had a census of 33 at</p>	K010000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

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>the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had a detached garage providing facility services including storage for extra resident beds, a snow blower and maintenance supplies that was not sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 10 or less residents in the activity room and the single resident in resident room 101.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Director on 04/25/13 from 1:25 p.m. to 1:28 p.m., the escutcheon was missing from the sprinkler head in the activity room closet and the sprinkler head in the closet of resident room 101 leaving a one half inch hole to the attic space above. This was acknowledged by the Maintenance Director at the time of</p>	K010025	<p>K 025</p> <p>1. Maintenance Director repaired 1/2" hole in closet of room 101 on 5/6/13, Maintenance Director installed a new escutcheon in the Activity Room Closet on 5/7/13.</p> <p>2. No other residents were found to be affected. This could have affected up to 10 residents in the Activity Room and a single resident in room 101. Maintenance Director repaired 1/2" hole in closet of room 101 on 5/6/13, Maintenance Director installed a new escutcheon in the Activity Room Closet on 5/7/13.</p> <p>3. Maintenance Director was re-educated on ensuring ceiling smoke barriers are maintained on 5/6/13. . Maintenance Director has added</p>	05/07/2013			

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	observations. 3.1-19(b)		Smoke Barriers to his preventative maintenance program and will monitor weekly to ensure they are in compliance and maintained. (See Attachment A) 4. Maintenance Director has added Smoke Barriers to his preventative maintenance program and will monitor weekly to ensure they are in compliance and maintained. (See Attachment A) Results of the monitoring, and any corrective actions taken, will be reviewed at least quarterly at the QA meetings.		

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K010048 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written plan that included the evacuation of a smoke compartment within the evacuation instruction of 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a record review with the Administrator and the Maintenance Director on 04/25/13 at 12:18 p.m., the "Fire Disaster Plan" states "in event that partial or total evacuation is deemed necessary, see Evacuation Procedure." The Administrator was unable to find</p>	K010048	<p>K 048</p> <p>1.All residents have the potential to be affected. Zone to Zone Evacuation instructions were moved by Administrator to the Evacuation Procedure section of all Disaster Manuals in the facility.</p> <p>1.All residents have the potential to be affected. Zone to Zone Evacuation instructions were moved by Administrator to the Evacuation Procedure section of all Disaster Manuals in the facility.</p> <p>1.Administrator will review Disaster Manuals monthly x 3 months then quarterly thereafter to ensure manuals are updated and organized according to table of contents.</p> <p>1.Administrator will review Disaster Manuals monthly x 3 months then quarterly to ensure manuals are updated and organized according to table of contents.</p> <p>Results of the monitoring, and any corrective actions taken, will be reviewed at least quarterly at the QA meetings.</p>	05/08/2013			

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	<p>evacuation of a smoke compartment in the Evacuation Procedure. The Maintenance Director did locate zone to zone evacuation instructions under the section labeled "Power loss" in the disaster manual. Based on an interview with the Administrator and the Maintenance Director at the time of record review, the evacuation of a smoke compartment was not found in the evacuation procedures as stated in the fire disaster plan.</p> <p>3.1-19(b)</p>			

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K010062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace 4 of 4 sprinkler head in the main entrance canopy which were corroded. 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, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 1 of 4 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director on 04/25/13 at 12:30 p.m., there was a buildup of green corrosion on the sprinkler heads in the main entrance canopy. At the time of observation the Maintenance Director acknowledged the canopy sprinkler heads were covered in corrosion.</p>	K010062	<p>K 062</p> <p>1.Any resident that may be utilizing the front porch has the potential to be affected. Maintenance Director called Elwood Fire on 5/13/13 to order 4 new sprinklers for the front porch that seemed to be corroded. Elwood Fire measured the 4 sprinkler heads on 5/14/13 and ordered the parts, upon arrival they will return and install the new heads. Maintenance Director cleaned the four sprinklers with a wash cloth until their appearance became new like.</p> <p>1.Any resident that may be utilizing the front porch has the potential to be affected. Maintenance Director called Elwood Fire on 5/13/13 to order 4 new sprinklers for the front porch that seemed to be corroded. Elwood Fire measured the 4 sprinkler heads on 5/14/13 and ordered the parts, upon arrival they will return and install the new heads. Maintenance Director cleaned the four sprinklers with a wash cloth until their appearance became new like. New sprinklers will be installed as soon as we get them.</p>	05/13/2013			

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	3.1-19(b)		<p>1.Maintenance Director was re-educated on checking the outside Sprinklers to ensure they are in compliance and maintained on 5/6/13. Maintenance Director has added outside sprinklers to his preventative maintenance program and will monitor weekly to ensure they are in compliance and maintained. (See Attachment A)</p> <p>1.Maintenance Director has added outside sprinklers to his preventative maintenance program and will monitor weekly to ensure they are in compliance and maintained. (See Attachment A) Results of the monitoring, and any corrective actions taken, will be reviewed at least quarterly at the QA meetings.</p>		

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K010066 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoking areas was provided with a self closing trash receptacle used to empty ashtrays only. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator and the Maintenance Director on 04/25/13 at 1:46 p.m., the self closing hard plastic trash can in the</p>	K010066	<p>K 066</p> <p>1.No residents were affected as the trash receptacle was not in a resident care area but could affect facility staff. A self closing trash receptacle was ordered on 5/6/13 and will be placed in the designated smoking area upon arrival.</p> <p>1.No residents have the potential to be affected. A self closing trash receptacle was ordered on 5/6/13 and will be placed in the designated smoking area.</p>	05/06/2013
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	<p>resident smoking area contained a mixture of cigarettes butts and combustibile trash. This was acknowledged by the Administrator and the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>		<p>1.Maintenance Director was re-educated on ensuring a self closing trash receptacle is available and maintained on 5/6/13. Maintenance Director has added the self-closing trash receptacle to his preventative maintenance program and will monitor weekly to ensure the self-closing trash receptacle is in place and utilized correctly. (See Attachment A)</p> <p>1.Maintenance Director has added the self-closing trash receptacle to his preventative maintenance program and will monitor weekly to ensure the self-closing trash receptacle is in place and utilized correctly. (See Attachment A) Results of the monitoring, and any corrective actions taken, will be reviewed at least quarterly at the QA meetings.</p>		

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K010076 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 exterior oxygen supply storage locations was protected from the weather. NFPA 99, 4-3.5.2.2(b)3 requires cylinders stored in the open shall be protected against extremes of weather. During winter, cylinders stored in the open shall be protected from against an accumulation of ice or snow. In summer, cylinders stored in the open shall be screened against continuous exposure to direct rays of the sun in those localities where extreme temperatures prevail. This deficient practice was not in a resident care area but could affect the facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director on 04/25/13 at 1:44 p.m., three large oxygen cylinders, approximately</p>	K010076	<p>K 076</p> <p>1.No residents were affected as Oxygen Tanks are not in a resident care area but could affect facility staff. Maintenance Director will build a protective Awning to protect the tanks from the elements. Materials for the Awning are being purchased starting on 5/8/13 and Maintenance Director will begin construction immediately.</p> <p>1.No residents have the potential to be affected. Maintenance Director will begin construction on a protective Awning immediately and will be completed by 5/17/13.</p> <p>1.Maintenance Director was re-educated on ensuring Outside Oxygen Storage Area is properly protected on 5/6/13. Maintenance Director has added the outside Oxygen tanks to his preventative</p>	05/17/2013			

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	<p>five feet tall, were stored in a chain link enclosure near the service corridor exit door. The chain link enclosure did not offer protection from sun, snow, or rain. Based on an interview with the Lead Respiratory Therapist on 05/03/13 at 8:10 a.m., the large oxygen cylinders are used to transfill oxygen. The Administrator and the Maintenance Director agreed at the time of observation, the oxygen cylinders were exposed to all types of weather conditions.</p> <p>3.1-19(b)</p>		<p>maintenance program and will monitor weekly. (See Attachment A)</p> <p>1.Maintenance Director has added the outside Oxygen tanks to his preventative maintenance program and will monitor weekly. (See Attachment A) Results of the monitoring, and any corrective actions taken, will be reviewed at least quarterly at the QA meetings.</p>	

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K010154 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to protect 33 of 33 residents by providing a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for more than 4 hours in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC, Section A.9.7.6.1 explains the individual conducting the fire watch should be specially trained in fire prevention, in the use of fire extinguishers, in notifying the fire department, in sounding the building fire alarm and in understanding the particular fire safety situation for public education purposes. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Fire Watch Policy and Procedure" with the Administrator and the Maintenance Director on 04/25/13 at 12:28 p.m., the</p>	K010154	<p>K 154</p> <p>1.All residents have the potential to be affected. In-service scheduled for all staff on Fire Watch policy and procedures on 5/13/13. Fire Watch policy has been revised include that a "trained" person will conduct the fire watch.</p> <p>1.All residents have the potential to be affected. In-service scheduled for all staff on Fire Watch policy and procedures on 5/13/13. Fire Watch policy has been revised include that a "trained" person will conduct the fire watch.</p> <p>1.Fire Watch Education will be added to New-Hire packets as well as addressed with our annual Fire Prevention In-Service. . Fire Watch policy has been revised include that a "trained" person will conduct the fire watch.</p> <p>1.Administrator will review Fire Watch Policy, Employee In-service records and New Hire</p>	05/13/2013			

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	<p>facility did have a written policy and procedure for an impaired sprinkler system available for review, but the policy did not state the designated person(s) conducting the fire watch shall be properly trained prior to conducting the fire watch. Based on an interview with the Administrator and the Maintenance Director at the time of record review, it was acknowledged the fire watch policy documentation lacked a statement indicating the person(s) conducting the fire watch shall be properly trained prior to conducting a fire watch.</p> <p>3.1-19(b)</p>		<p>packets to ensure all employees are properly trained in Fire Watch Procedures. Fire Watch Policy and Employee In-service records will be reviewed at least quarterly at the QA meetings to ensure proper training.</p>	

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K010155 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 33 of 33 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. LSC 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice affect all occupants.</p>	K010155	<p>K 155</p> <p>1.All residents have the potential to be affected. In-service scheduled for all staff on Fire Watch policy and procedures on 5/13/13. Fire Watch policy has been revised include that a "trained" person will conduct the fire watch.</p> <p>1.All residents have the potential to be affected. In-service scheduled for all staff on Fire Watch policy and procedures on 5/13/13. Fire Watch policy has been revised include that a "trained" person will conduct the fire watch.</p> <p>1.Fire Watch Education will be added to New-Hire packets as well as addressed with our annual Fire Prevention In-Service. . Fire Watch policy has been revised include that a "trained" person will conduct the fire watch.</p> <p>1.Administrator will review Fire Watch Policy and Employee In-service records to ensure all employees are properly trained in</p>	05/13/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2013
NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750		
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	<p>Findings include:</p> <p>Based on review of the "Fire Watch Policy and Procedure" with the Administrator and the Maintenance Director on 04/25/13 at 12:28 p.m., the facility did have a written policy and procedure for an fire alarm system available for review, but the policy did not state the designated person(s) conducting the fire watch shall be properly trained prior to conducting the fire watch. Based on an interview with the Administrator and the Maintenance Director at the time of record review, it was acknowledged the fire watch policy documentation lacked a statement indicating the person(s) conducting the fire watch shall be properly trained prior to conducting a fire watch.</p> <p>3.1-19(b)</p>		<p>Fire Watch Procedures. Fire Watch Policy and Employee In-service records will be reviewed at least quarterly at the QA meetings to ensure proper training.</p>		