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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155386 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>03/05/2015 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>LAURELS OF DEKALB | STREET ADDRESS, CITY, STATE, ZIP CODE<br>520 W LIBERTY ST<br>BUTLER, IN 46721 |
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| K 000<br><br>Bldg. 01 | <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: 03/05/15</p> <p>Facility Number: 000574<br/>Provider Number: 155386<br/>AIM Number: 100266430</p> <p>Surveyor: Thomas Forbes, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Laurels of Dekalb 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) and 410 IAC 16.2. The original building consisting of the 100, 200, 300 and 400 halls, the main dining room and the service hall was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire</p> | K 000         | <p>The Laurels of DeKalb wishes to have this submitted plan of correction stand as our written allegation of compliance. Preparation and/or execution of this plan does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. Our date of compliance is April 4, 2015</p> |                      |

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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| K 021<br>SS=E<br>Bldg. 01 | <p>alarm system with smoke detection in in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 101 and had a census of 87 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility had a detached garage providing facility services including storage of beds, mattresses and snow blowers that was not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/12/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a</p> |               |   |                      |

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|   | <p>required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 kitchen doors was provided with hold open device that would release with the fire alarm with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice was not in a patient treatment area but could affect any staff in the Kitchen and Service Hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Nursing and the Maintenance Director on 03/05/15 at 12:22 p.m., the kitchen door to the Service Hall was equipped with a self closing device and latched in to the frame but was held open with a device that would not release with the fire alarm. The kitchen door was held open by a trash bag tied to door and to a sink. Based on interview at the time of observation, the Director of Nursing and the Maintenance Director acknowledged the door was being held open by a trash bag and removed the trash bag.</p> <p>3.1-19(b)</p> | K 021   | <p>On 3/5/15 the Maintenance Director removed the trash bag holding open the kitchen door and then closed the door. No other facility doors were found to be in violation of the regulation. By 4/4/15 all Dietary Personnel will be in-serviced on this regulation. Continued compliance of the regulation will be monitored by the Maintenance Director and Dietary Manager through the facility preventative maintenance program. Variances will be corrected at the time of the observation and trends will be reported to the facility's monthly Safety and Quality Assurance Committee. The Administrator is responsible with this regulation.</p> | 04/04/2015           |   |

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| K 025<br>SS=E<br>Bldg. 01                             | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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 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 can affect 24 residents on the 400 hall.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Director of Nursing and the Maintenance Director on 03/05/15 between 10:25 a.m. and 10:30 a.m., the following penetrations were noted:</p> <p>a. one unsealed penetrations through the ceiling measuring a half of an inch around the sprinkler head in the restroom of room 405.</p> <p>b. one unsealed penetration through the</p> | K 025   | <p>On 3/20/15 the Maintenance Director completed repair work to the unsealed penetrations around the sprinkler heads in both rooms 405 and 409. The penetrations were repaired by raising the sprinkler pipe in the attic. The facility's Maintenance Director will ensure each room in the facility contains no penetrations around the sprinkler heads as stated in the regulation. Continued compliance of the regulation regarding penetrations around sprinkler heads will be monitored by the Director of Maintenance through the preventative maintenance and fire safety programs. Variances will be corrected at the time of observation and trends will be reported to the facility's monthly Safety Committee and Quality Assurance Committees. The Administrator will monitor compliance with this regulation.</p> | 04/04/2015           |   |

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| K 029<br>SS=E<br>Bldg. 01 | <p>ceiling measuring a half of an inch around the sprinkler head in room 409. Based on interview at the time of observation, the Maintenance Director acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms, a hazardous area, located in the service hall was smoke resistive. This deficient practice was not in a patient treatment area but could affect any staff in the Laundry and Service Hall.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Director of Nursing and the Maintenance Director on</p> | K 029         | <p>On 3/20/15 the Maintenance Director completed repair work to the unsealed penetration in the ceiling on one side of the dryer ventilation duct. The penetration was repaired with thinset and fire caulk. The facility's Maintenance Director will ensure each room in the facility contains no penetrations in the ceilings as stated in the regulation. Continued compliance of the regulation regarding penetrations in the ceilings will be monitored by the Director of Maintenance through the preventative maintenance and fire safety</p> | 04/04/2015           |

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| K 066<br>SS=F<br>Bldg. 01                             | <p>03/05/15 at 12:25 p.m., in the laundry room behind the dryers there was a two inch unsealed penetration in the ceiling on one side of the dryer ventilation duct. Based on interview at the time of observation, the Maintenance Director acknowledged and provided the measurement of the penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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<br/>Based on observation and interview, the facility failed to ensure 1 of 1 resident</p> | K 066   | <p>programs. Variances will be corrected at the time of observation and trends will be reported to the facility's monthly Safety Committee and Quality Assurance Committees. The Administrator will monitor compliance with this regulation.</p> <p>By 4/4/15 the facility will replace the cigarette butt disposal container located at the facility</p> | 04/04/2015  |  |   |  |

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|   | <p>smoking areas and 1 of 1 main entrance butt disposal area were properly maintained and provided with a self closing trash receptacle. This deficient practice could affect up to 10 residents in the smoking area and all staff, visitors, and resident using the main entrance.</p> <p>Findings include:</p> <p>Based on paper review and observation during the tour of the facility with the Director of Nursing and the Maintenance Director on 03/05/15 between 10:00 a.m. and 1:45 p.m., the following smoking regulations were not followed:</p> <p>a. the butt disposal area located at the entrance of the facility, which is not a designated smoking area, did not have a metal container with a self closing covered receptacle to dispose of cigarette butts. The facility was using a trash can with a top mounted uncovered ash tray to dispose of cigarette butts.</p> <p>b. the resident smoking area in the courtyard was provided with an approved container for disposing cigarette butts, but there was a trash container full of paper goods that was mixed with 10 cigarette butts. Also, there was at least 10 cigarette butts in the rocks of the resident smoking area.</p> <p>Based on interview at the time of observation, the Director of Nursing and</p> |   | <p>entrance with a container that complies with the regulation. By 4/4/15 the resident smoking area in the courtyard will be free of cigarette butts in the landscaping and the trash receptacle will be removed from the courtyard. Continued compliance with the regulation will be monitored by the Director of Maintenance through the facility's preventative maintenance program. Any variances will be corrected at the time of observation and trends will be reported through the facility's Safety and Quality Assurance Committee. The Administrator will monitor compliance with this regulation.</p> |                      |   |

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| K 067<br>SS=F<br>Bldg. 01 | <p>the Maintenance Director acknowledged the facility's smoking regulations were not followed.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 5 of 6 egress corridors were not being used as a portion of the return air plenum for heating, ventilating and air conditioning ductwork (HVAC) serving adjoining areas. NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice affects the 100, 200, 300 and 400 halls therefore affecting all residents.</p> <p>Findings include:</p> <p>Based on observations with the Director of Nursing and the Director of</p> | K 067         | The facility respectfully requests a waiver of K067. The Life Safety Waiver request will be received by the State by 3/25/15. | 04/04/2015           |

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| K 130<br>SS=E<br>Bldg. 01                             | <p>Maintenance on 03/05/15 during the facility tour from 10:00 a.m. to 2:00 p.m., all resident rooms on the 100, 200, 300 and 400 halls were using the egress corridor as a return air system. Based on an interview at the time of observation, the Director of Maintenance confirmed the return air was exhausted into the corridor for all resident rooms.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>MISCELLANEOUS<br/>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview, the facility failed to ensure 2 of 5 water heaters had a current inspection certificate to ensure the water heater was in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of residents. An inspection is required on water heaters if any of the three parameters are exceeded:</p> <ol style="list-style-type: none"> <li>1. Storage capacity does not exceed 80 gallons.</li> <li>2. Input does not exceed 100,000 BTU's/hour.</li> <li>3. Relief valve set pressure does not exceed 150 PSIG.</li> </ol> <p>This deficient practice affects the 21 resident in the 200 hall and any number</p> | K 130   | <p>By 4/4/15 the 100 gallon water heater located in the 200 hall will be inspected by Zurich inspection company and a state Operating Permit will be issued. By 4/4/15 the 80 gallon water heater in the heater room in the service hall will be inspected by Zurich inspection company and a state Operating Permit will be issued. The Director of Maintenance will ensure the facility's boiler and water heater inspections are kept current. Continued compliance with the regulation will be monitored by the Director of Maintenance through the facility's preventative maintenance program. Any variances will be corrected at the time of observation and trends will be reported through the facility's Safety and Quality Assurance</p> | 04/04/2015  |  |   |  |

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| K 000<br><br>Bldg. 02                                 | <p>of staff in the service hall.</p> <p>Findings include:</p> <p>Based on record review and observation during a tour of the facility with the Director of Nursing and the Maintenance Director on 03/05/15 from 10:55 a.m. to 12:30 p.m., the following water heaters lacked an inspection certificate and/or a State Identification tag:</p> <p>A) The 100 gallon water heater in the communication room located on the 200 hall with a BTU rating of 85,000.</p> <p>B) The 80 gallon water heater in the heater room located on the service hall with a BTU rating of 199,999.</p> <p>Based on interview at the time of observation, the Maintenance Director stated the two water heaters have never been inspected. When asked why the two water heaters have never been inspected, the Maintenance Director stated the water heaters were new and he was told the type of water that was installed does not require a state inspection.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey Survey was</p> | K 000   | <p>Committee. The Administrator will monitor compliance with this regulation.</p> <p>The Laurels of DeKalb wishes to have this submitted plan of</p> |                      |   |

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|   | <p>conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/05/15</p> <p>Facility Number: 000574<br/>Provider Number: 155386<br/>AIM Number: 100266430</p> <p>Surveyor: Thomas Forbes, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Laurels of Dekalb 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) and 410 IAC 16.2. The new section of the building consisting of the 300 hall Therapy gym was surveyed with Chapter 18, New Health Care Occupancies.</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 in the corridors, areas open to the corridors and battery operated smoke detector in the resident rooms. The facility has a capacity of 101 and had a census of 87 at</p> |   | <p>correction stand as our written allegation of compliance. Preparation and/or execution of this plan does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. Our date of compliance is April 4, 2015</p> |                      |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION      |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155386 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>02</u><br>B. WING _____   |                      | X3) DATE SURVEY COMPLETED<br><br>03/05/2015 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>LAURELS OF DEKALB |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>520 W LIBERTY ST<br>BUTLER, IN 46721                                   |                      |   |
| (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 |   |
|   | <p>the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility had a detached garage providing facility services including storage of beds, mattresses and snow blowers that was not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/12/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> |   |   |                      |   |