

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/01/2015
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NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542
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K 000  Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 03/23/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/01/2015</p> <p>Facility Number: 000491 Provider Number: 155495 AIM Number: 100291230</p> <p>At this PSR survey, Lakeland Rehabilitation and Healthcare Center 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 corridors and battery operated smoke detectors in the</p>	K 000	<p><b>The facility requests paper compliance for this citation.</b></p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p>	
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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 025 SS=E Bldg. 01	<p>resident rooms. The facility has a capacity of 60 and had a census of 50 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility has a shed providing facility services including the storage of maintenance supplies and lawn equipment that was not sprinklered. The facility has two additional off site storage units. One unit is used for the storage of maintenance parts and supplies and the other is used for the storage of activity supplies. The off site storage unit were not sprinklered.</p> <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 the penetrations caused by the passage of wire and/or conduit through 1 of 4 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier.</p>	K 025	K 025 NFPA 101 LIFE SAFETYCODE STANDARDS	05/01/2015			

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	<p>LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect residents in two of four smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with the Environmental Services Director and Director of Social Services on 05/01/2015 at 11:06 a.m., the 200 hall smoke barrier wall had unsealed penetrations. Above the ceiling tile were the unsealed penetrations which were 3/4 inch to 2 inch holes to allow phone cables and sprinkler piping to pass through. Based on interview, this was acknowledged by the Environmental Services Director and Director of Social Services at the time of observation.</p> <p>3.1-19(b)</p> <p>This deficiency was cited on 05/01/2015.</p>		<p><b>The facility requests paper compliance for this citation.</b></p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p><b>1) Immediate actions taken for rooms identified on 200 Hall:</b></p> <p>a. Based on observation on 05/1/15 at 11:06 a.m., the penetrations in the compartment smoke barrier was filled with fire retardant material. A conduit penetration in the barrier had been filled with fire caulk part of which had fallen out leaving a gap. Maintenance will ensure that identified smoke</p>	

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	The facility failed to implement a systematic plan of correction to prevent recurrence.		barriers are properly sealed with Fire Caulk. Based on observation on 05/1/15 at 11:06 a.m., a ¾" to 2" inch holes in the firewalls in the attic above. Maintenance has patched, sealed, and repaired the holes identified as being open in the attic between fire walls. Correction has been completed and facility will allege compliance May 1, 2015. Photographic  <b>2) How the facility identified other environmental concerns:</b>  a. A 100% smoke compartment/smoke barrier inspection has been completed by the maintenance director additional precaution to review repaired smoke barriers.		

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			<p><b>3) Measures put into place / System changes:</b></p> <p><b>a.</b> Administrator/Designee will review maintenance records to ensure compliance monthly for six months and Corporate Environmental Consultants will review records and building during routine monthly visits. An up dated entry will include this audit which will be forwarded to monthly QA meeting minutes.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p><b>a.</b> Administrator/Designee will review maintenance records to ensure compliance monthly for six months and Corporate Environmental Consultants will review records and building during</p>	

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			<p>routine visits. If inspections identify areas needing additional repairs they are to be re-caulked and a record of repairs kept in the maintenance director's office.</p> <p><b>5) Responsible Person</b></p> <p>Administrator/Designee</p> <p><b>6) Date of Compliance</b></p> <p>Facility alleges compliance May 1, 2015.</p>		