

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155297	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/15/2012
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NAME OF PROVIDER OR SUPPLIER  CONTINUING CARE CENTER OF LAPORTE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1007 LINCOLNWAY LA PORTE, IN 46350
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/15/12</p> <p>Facility Number: 000194 Provider Number: 155297 AIM Number: 100267790</p> <p>Surveyor: Dennis Austill, Life Safety Code Supervisor</p> <p>At this Life Safety Code survey, Continuing Care Center of LaPorte Hospital 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 facility is located on the fifth floor and one wing of the sixth floor of a seven story building determined to be of Type II (111) construction separated from the existing hospital by a 2 hour fire wall and</p>	K0000		

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>is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Resident rooms were not provided with smoke detectors. The facility has a capacity of 55 and had a census of 40 at the time of this visit.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and not in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/22/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0012 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>Based on record review and interview, the facility failed to ensure the building construction type was a permitted type as listed in Table 19.1.6.2. Table 19.1.6.2 requires a building, four or more stories in height, to be Type II (222), Type I (332) or Type I (443). This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Fire Safety Evaluation System (FSES) documentation dated 08/03/12 and interview with the Director of Facilities and Environment of Care Safety Officer on 08/15/12 at 10:15 a.m., the facility was determined to be of Type II (111) construction and seven stories tall with a basement. The concrete floor slab in the North Tower is only 2 1/2" thick. This results in a construction type classification of II (111). The attached South Tower is Type I (332) construction and is separated from the North Tower on all stories by a 2 hour fire barrier wall.</p> <p>3.1-19(b)</p>	K0012	A Life Safety Code Waiver was Request has been submitted along with a FSES was conducted Please see attached. This process will be monitored annually by the Facilities Department.	08/30/2012			

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K0038 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation, record review and interview; the facility failed ensure 3 of 3 vertical exit egress towers provided a means of egress which discharge to the exterior or the public way in accordance with requirements of NFPA 101, 2000 edition, 7.7. 7.7.1 requires exits to discharge directly to a public way or exterior exit discharge. 7.7.2 allows no more than 50 percent of the exits or egress capacity to discharge into areas on the level of exit discharge. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Fire Safety Evaluation System (FSES) documentation dated 08/03/12 and interview with the Director of Facilities and Environment of Care Safety Officer on 08/15/12 at 10:15 a.m., exit stairs # 3 &amp; # 4 in the North Tower and exit stair # 5 in the South Tower do not discharge to the exterior through an approved exit passageway at the first floor level. Based on observation and interview with the Director of Facilities and Environment of Care Safety Officer during the tour from 11:30 a.m. to 1:00</p>	K0038	A Life Safety Code Waiver was Request has been submitted along with a FSES was conducted Please see attached. This process will be monitored annually by the Facilities Department.	09/03/2012			

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	p.m., the exit stair discharge was confirmed.  3.1-19(b)			

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K0062 SS=B	<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 ensure the spray pattern for 1 of 1 sprinkler heads within the fifth floor soiled utility room (5255) was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition, Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice does not directly affect residents since this area is accessible to only staff members.</p> <p>Findings include:</p> <p>Based on observation with the Environment of Care Safety Officer on 08/15/12 during the tour at 12:20 p.m., the one sprinkler head in the fifth floor soiled utility room (5255) was obstructed</p>	K0062	There were no residents affected by this deficient practice. The light in th Room #5255 has been removed and relocated away from the sprinkler head. This is a celing mounted light that has a 2" profile from ceiling. We moved it 18" away from the sprinkler head. During semi-annual environmental rounds all lights will be evaluated to make sure a 18" clearance is maintainted from the sprinkler. Any deficiencies will be reported to the EOC committee.	08/30/2012			

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	<p>by light fixture in such a way the spray pattern of the sprinkler head would not provide adequate coverage of the room. Based on interview at the time of observation, it was acknowledged by the Environment of Care Safety Officer the spray pattern of the sprinkler head would not provide adequate coverage of the room.</p> <p>3.1-19(b)</p>			

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K0070 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on record review and interview, the facility failed to ensure the portable space heater policy included language indicating the heating element of space heaters permitted in nonsleeping, employee areas would not exceed 212 degrees Fahrenheit (F). This deficient practice could affect any occupant.</p> <p>Findings include:</p> <p>Based on review of the "LaPorte Hospital Portable Space Heater Policy" with the Director of Facilities and Environment of Care Safety Officer at 10:00 a.m. on 08/15/12 with an effective date of 03/03/08, step 2 of the the procedure indicated, "The Life Safety Code and LaPorte Regional Health System does permit portable space heaters provided they are used in nonsleeping, employee areas. If assistance is needed in determine if a portable space heater is allowed, please contact the Engineering Department and/or the Environment of Care Safety Officer. Based on interview at the time of record review, the Director</p>	K0070	No residents were affected by this deficient practice. During on-going semi-annual eviormental rounds any use of space heaters will be looked for. Policy number Adm-SS-084 was revised and now states portable space heaters are not authorized for use anywhere in the IUHealth LaPorte Hosptial building. Effective 9/1/20. Any deficiency in this area will be reported to the EOC committee.	09/01/2012			

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	<p>of Facilities and Environment of Care Safety Officer acknowledged the policy did not include the limitation of the heating element to be 212 degrees F or less.</p> <p>3.1-19(b)</p>			

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K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure annual load testing was conducted for 3 of 3 generators when the requirements of NFPA 110, 1999 Edition, Standard for Emergency and Standby Power Systems, 6-4.2 were not met. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>NFPA 110 6-4.2.2 requires diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30</p>	K0144	<p>All residents have the potential to be affected by this deficient practice. Based on evidence found on our generators the follow measures have been put into place.1. Schedule of a yearly load bank test to be completed before 9/15/2012. 2. Monthly testing by the hospital will continue as scheduled now3. A yearly load bank test will be scheduled to comply with NFPA 1104. The policy was changed to add the yearly load bank test to the policy 5. The EOC committee will monitor the compliance of this deficiency. All testing will be reported to the EOC committee.6. By completing a yearly load bank test we will supply enough load to the generators to hit our temperatures required.</p>	09/15/2012			

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	<p>minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.</p> <p>NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the "Emergency Generator - Monthly Test Log" documentation for the hospital's three generators with the Director of Facilities and Environment of Care Safety Officer at 10:45 a.m. on 08/15/12, generators # 1 and # 2 did not achieve 30 % of the nameplate rating for 6 of the 12 past months and generator # 3 did not achieve 30% of the nameplate rating 11 of the past 12 months. The normal operating temperature of all three generators was listed, "180 degrees Fahrenheit to 200 degrees Fahrenheit." The temperatures were recorded at start up and at ten minutes and were consistently less than 180 degrees Fahrenheit. Based on record review and interview with the Director of Facilities and Environment of Care Safety Officer at 10:45 a.m., the last documented load bank test was dated 10/19/2010.</p>			

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K0147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sinks in the fifth floor staff charting room wet location was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as areas subjected to wet conditions. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect any staff using the fifth floor staff charting room sink in the event of an electrical short.</p> <p>Findings include:</p> <p>Based on observation with the Director of Facilities and Environment of Care Safety Officer on 08/15/12 during the tour at 12:45 p.m., the fifth floor staff charting room had an electrical receptacle on the wall within three feet of the sink which</p>	K0147	No residents had the potential of being affected by this deficient practice. This outlet has been changed to a GFCI outlet. Completed 8/31/2012. During on-going semi-annual environmental rounds these outlets will be monitored and any deficiencies will be reported to the EOC committee for compliance.	08/31/2012

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	<p>was not provided with GFCI protection to prevent electric shock. This was acknowledged by the Director of Facilities and Environment of Care Safety Officer at the time of observation.</p> <p>3.1-19(b)</p>			

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by:</p> <p>Based on observation and interview, the facility failed to install smoke detectors in each of the 55 resident's room before July 1, 2012. This deficient practice could affect at least 40 residents in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Director of</p>	K9999	All residents have the potential to be affected by this deficient practice. 1. All 55 resident rooms had battery operated smoke detectors installed completed 8/31/2012.2. We have established a written policy to monitor battery life semi-annually through our on going preventive maintenance system. The batteries have been added to the preventive maintenance program. Evidence was sent to Dennis Austill on 8/31/2012 by e-mail on final installation of smoke detectors. 3. Eviornmental Services will report semi-annually to the EOC committee when the batteries have been changed in all detectorsduring preventative maintance rounds. The EOC committee will monitor for compliance.	08/31/2012			

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NAME OF PROVIDER OR SUPPLIER  CONTINUING CARE CENTER OF LAPORTE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1007 LINCOLNWAY LA PORTE, IN 46350
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(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>Facilities and Environment of Care Safety Officer on 08/15/12 during the orientation tour at 9:45 a.m., the 55 resident rooms were not provided with smoke detectors. This was acknowledged by the Director of Facilities and Environment of Care Safety Officer during the time of observation.</p> <p>3.1-19(ff)</p>			