

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155449	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/12/2012
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NAME OF PROVIDER OR SUPPLIER NORTHERN LAKES NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 516 N WILLIAMS ST ANGOLA, IN 46703
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K0000	<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: 12/12/12</p> <p>Facility Number: 000426 Provider Number: 155449 AIM Number: 100275480</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Northern Lakes Nursing and Rehabilitation 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 (000)</p>	K0000	<p>Submission of this response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency, was correctly cited, and is not to be construed as an admission of interest against the facility, the administrator, or any employees, agents or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Included is the Plan of Correction for our annual Life Safety Recertification and State Licensure Survey for Northern Lakes Nursing & Rehabilitation Center. The Plan of Correction is also to serve as our Credible Allegation of Compliance.</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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	<p>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 150 and had a census of 81 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had a maintenance building providing facility services including the maintenance office and tools that was not sprinklered. The facility has an additional off site storage unit including the storage of beds and mattresses that was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/14/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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>1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 clean linen storage rooms with combustibles on Piers hall measuring over 50 square feet in size, self closed and latched into the door frame. This deficient practice could affect any of the 17 residents on the Piers hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 12/12/12 at 11:40 a.m., the corridor door to the Piers clean linen storage room with combustible storage, measuring over 64 square feet in size, did self close but it failed to latch into</p>	K0029	<p>K OO29 1. The maintenance department immediately repaired the latch to the Piers Clean Linen Storage Room. An entire facility inspection was completed by the Maintenance Director on all doors in facility to ensure no further issues noted. The Maintenance Director increased door inspections to weekly on his Preventative Maintenance Schedule. In addition, all environmental staff (housekeeping & laundry) were re-instructed on door requirements including self closure and latching, they were also re-instructed on use of Repair Requisitions for needed maintenance service. Maintenance will provide the Quality Assurance Committee copies of weekly inspections completed on doors weekly for 4 weeks. If the QA committee determines continued compliance has been maintained,</p>	01/11/2013

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	<p>the door frame.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 Sandy Shore hazardous storage area was separated from the corridor by smoke resistive partitions and doors. This deficient practice could affect any of the 19 residents on the Sandy Shore hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 12/12/12 from 12:05 p.m., to 2:05 p.m., a 40 gallon soiled linen container, approximately one third full, was unattended and stored in the Sandy Shore hall. Based on an interview with the Maintenance Director at 12:05 p.m., he acknowledged the soiled linen container should be stored in the soiled utility room when not in use.</p> <p>3.1-19(b)</p>		<p>then reporting will follow the normal QA Schedule for Quarterly Reporting. 2. I cannot determine based on times indicated on form 2567 that in fact these soiled linen containers were actually stored in the Sandy Shore Hall. The times checked at 12:05 p.m. is a normal time that the containers would be in the hall for after lunch checks, and 2:05 pm is the start of 2nd shift which is a time that they do their first bed checks for this shift, so it would be expected that they would have been found at both times in the hall. When bed check was completed, the nurse aides did place storage containers in the shower room on Sandy Shores. All other halls were inspected by the Environmental Director and found all to be in compliance. The Maintenance Director has re-instructed nursing and environmental staff on appropriate storage of soiled linen containers. Daily checks are completed at this time by the Environmental Director and Maintenance Director or designee and weekly report provided to the Quality Assurance Committee. If the QA Committee determines continued compliance after 4 weeks of daily inspections, this will be reviewed for continued compliance at the Quarterly QA Meeting.</p>		

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K0038 SS=E	<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 and interview, the facility failed to ensure 1 of 4 exit access corridors was readily accessible and unobstructed at all times. This deficient practice could affect any of the 19 residents on Sandy Shore hall.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 12/12/12 at 2:10 p.m., a portable scale, two clean linen carts and a 40 gallon soiled linen container were stored in the Sandy Shore corridor from 12:05 p.m. to 2:05 p.m. Based on an interview with the Maintenance Director at 2:10 p.m., these items were only supposed to be in the corridor when they are in use.</p> <p>3.1-19(b)</p>	K0038	<p>K 0038 When bed check was completed, the nurse aides did place storage containers in the shower room on Sandy Shores. The Environmental Director did place the clean linen cart and scale in the Sandy Shore Shower Room for storage. All other halls were inspected by the Environmental Director and found all to be in compliance. The Maintenance Director has re-instructed nursing and environmental staff on appropriate storage of soiled linen containers, clean linen carts, and scales. Daily checks are completed at this time by the Environmental Director and Maintenance Director or designee, and weekly report provided to the Quality Assurance Committee. If the QA Committee determines continued compliance after 4 weeks of daily inspections, this will be reviewed for continued compliance at the Quarterly QA Meeting.</p>	01/11/2013			

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K0050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills included activating the fire alarm system for 12 of the last 12 calendar months. This deficient practice affects all residents.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 12/12/12 at 12:50 p.m., fire drills were conducted each month on every shift for the last 12 months. Based on an interview with the Maintenance Director at the time of record review, the fire alarm system is only activated during the first shift fire drill every month. The second and third shift drills, which are conducted the same day as the first shift drill, are coded</p>	K0050	<p>K 0050 The Administrator re-instructed the maintenance director on conducting fire drills including what hours he can conduct coded announcement versus audible alarm drills. The Fire Drill Report was updated to include policy on conducting coded announcement, and an area to indicate if drill was coded announcement or audible alarm. This was reviewed and approved by the Quality Assurance Committee. Completed Fire Drill Reports will be provided to the administrator each month, and will be reviewed in Quality Assurance Committee at each meeting for continued compliance.</p>	01/11/2013			

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K0069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure the baffle filters in 1 of 1 kitchen exhaust systems were installed correctly. NFPA 96,1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 3-2.5 states filters shall be installed at an angle not less than 45 degrees from the horizontal. This deficient practice could affect kitchen staff.</p> <p>Finding include:</p> <p>Based on observation with the Maintenance Director on 12/12/12 at 1:51 p.m., the baffle filters were aligned horizontally in the kitchen range hood exhaust system preventing the grease and other material from dripping into the trough for removal. At the time of observation, the Maintenance Director stated he was not aware the baffles should not be installed horizontally.</p> <p>3.1-19(b)</p>	K0069	The maintenance director immediately removed the baffle filters for the exhaust system and re-installed 45 degrees from the horizontal. The Dietary Manager and kitchen staff were re-instructed on re-installing baffle filters when they are removed for cleaning. The Dietary Manager provided the maintenance director with a cleaning schedule for the baffle filters and he was instructed to inspect this after each cleaning for proper reinstallation each week. This inspection will be provided to the Quality Assurance Committee for review at each scheduled meeting.	01/11/2013			

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K0075 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square feet area for 1 of 4 corridors. This deficient practice could affect any of the 19 residents on Sandy Shore hall.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 12/12/12 at 2:05 p.m., a 40 gallon soiled linen container, approximately one third full, was unattended and stored in the Sandy Shore corridor from 12:05 p.m. to 2:05 p.m. Based on an interview with the Maintenance Director at the time of observation, he stated the soiled</p>	K0075	I cannot determine based on times indicated on form 2567 that in fact these soiled linen containers were actually stored in the Sandy Shore Hall. The times checked at 12:05 p.m. is a normal time that the containers would be in the hall for after lunch checks, and 2:05 pm is the start of 2nd shift which is a time that they do their first bed checks for this shift, so it would be expected that they would have been found at both times in the hall. When bed check was completed, the nurse aides did place storage containers in the shower room on Sandy Shores. All other halls were inspected by the Environmental Director and found all to be in compliance. The Maintenance Director has re-instructed nursing and environmental staff on appropriate storage of soiled linen containers. Daily checks are completed at this time by the Environmental Director and Maintenance Director or designee	01/11/2013

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	linen container should be stored in the soiled utility room when not in use. 3.1-19(b)		and weekly report provided to the Quality Assurance Committee. If the QA Committee determines continued compliance after 4 weeks of daily inspections, this will be reviewed for continued compliance at the Quarterly QA Meeting.	

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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 observation and interview, the facility failed to provide a functional remote generator annunciator panel for 1 or 1 emergency generators. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator be provided in a location readily observable by operating personal at a regular work station. LSC 4.6.12.1 requires any device or equipment required for compliance with this Code shall thereafter be continuously maintained. NFPA 72, 7-4.3 requires all apparatus requiring resetting to maintain normal operations shall be reset as promptly as possible after each test and alarm. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 12/12/12 at 12:15 p.m., the generator annunciator panel horn switch was turned to the off</p>	K0144	The Maintenance Director immediately turned the annunciator panel horn back on. No other Generator annunciator panels are within the facility to check. The Maintenance Director and Maintenance staff was re-instructed on inspecting the Generator annunciator panel daily as part of their preventative maintenance schedule. The maintenance director did place a lock cover over this switch to prevent any further issues with the generator annunciator panel horn being turned off. The Preventative Maintenance Schedule was updated to include visual inspection of this panel daily. The Quality Assurance Committee reviewed and approved updated schedule. A copy of the completed PM Schedule will be provided to the Quality Assurance Committee for review at each scheduled meeting for continued compliance.	01/11/2013			

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	<p>position. The generator annunciator panel was located near the back nurses' station. Based on an interview with the Maintenance Director at the time of observation, he was unsure how long the generator annunciator panel horn switch was turned to the off position.</p> <p>3.1-19(b)</p>			