

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  05/04/2016
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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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K 0000  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: 05/04/16</p> <p>Facility Number: 000569 Provider Number: 155531 AIM Number: 100267660</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 36 at the time of this survey.</p>	K 0000	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.	
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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 0025 SS=E Bldg. 01	<p>All areas where the residents have customary access were sprinklered. The facility had a detached garage providing facility services including extra resident beds, a snow blower and maintenance supplies that was not sprinklered.</p> <p>Quality Review completed on 05/06/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were 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 26 residents in 2 of 4 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Director on 05/04/16 between 10:00 a.m. 11:00</p>	K 0025	<p><b>K 025 NFPA 101 LIFESAFETY CODE - Smoke Barriers</b></p> <p>1. and 2. No residents were affected but all residents have the potential to be affected by this alleged deficient practice. Maintenance Supervisor sealed all noted penetrations in the maintenance office, 100 hall mechanical room, 200 hall mechanical room, and the Sprinkler riser room. Maintenance supervisor sealed all noted penetrations in the 100 hall smoke wall and around wires in the attic.</p> <p>3. Smoke barriers have been added to the facility's preventative maintenance program (See</p>	05/16/2016

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	<p>a.m., the following areas had unsealed ceiling penetrations</p> <p>a) In the maintenance office there were five unsealed fourth of an inch penetrations around a wires and a half inch penetration around a duct.</p> <p>b) In the 100 mechanical room there was a half inch penetration around a duct.</p> <p>c) In the 200 mechanical room there was a two inch hole around a duct and pipe.</p> <p>d) In the sprinkler riser room there were five half inch penetration around a pipes.</p> <p>Based on interview at the time of observation, the Maintenance Director acknowledge and provided the Measurements of the penetration.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 3 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. 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</p>		<p>attachment A). The smoke barriers will be checked weekly bythe Maintenance Director.</p> <p>4. Maintenance Supervisor will monitor anddocument weekly Smoke Barrier Integrity as part of the weekly preventative maintenance program. Should a concern be found, immediate corrective actionwill occur. Results of these reviews andany corrective actions will be discussed in the facility's monthly QA meetingson an ongoing basis for a minimum of 6 months and the plan adjusted ifindicated.</p>	

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K 0046 SS=F Bldg. 01	<p>smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 26 residents in one of 2 of 4 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 05/04/16 from 11:00 a.m. to 11:35 a.m., there was a three inch hole in the dry wall due to water damage in the 100 hall smoke wall above the ceiling tiles and two unsealed half inch penetrations around wires in the attic. 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 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 6 of 6 battery powered emergency exit lights were tested monthly and annually. LSC 7.9.3 Periodic Testing of Emergency Lighting</p>	K 0046	<p><b>K 046 NFPA 101 LIFE SAFETY CODE – EmergencyLighting</b></p> <p>1. and 2. No residents were affected but all residents have the potential to be affected by this alleged deficient practice. The Maintenance</p>	05/16/2016

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	<p>Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. In addition, NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 05/04/16 between 9:30 a.m. and 11:00 a.m. six battery operated emergency exit lights were observed at each of the facility's six exits. Based on an interview at the time of observation, the Maintenance Director stated the six exit lights were only checked weekly for about ten seconds, no monthly or annually check are conducted.</p>		<p>tested the exit lighting on 5/11/16 for 30 seconds and again on 5/12/16 for 90 minutes.</p> <p>3. The facility's preventative maintenance program has been revised to include checking the exit lighting monthly for 30 seconds and annually for 90 minutes (See Attachment B).</p> <p>4. Maintenance Supervisor will monitor and document monthly and annually the required exit lighting tests as part of the preventative maintenance program. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed at the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the plan adjusted if indicated.</p>	

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K 0062 SS=F Bldg. 01	<p>3.1-19(b)</p> <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 record review and interview, the facility failed to ensure 1 of 1 automatic dry sprinkler piping systems was inspected every five years as required by NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 05/04/15 at 09:35 a.m., the Elwood Fire Systems internal pipe letter indicated an internal inspection of the pipes had been completed on 5-18-2010. Based on an interview with the Maintenance Director at the time of record review, no other documentation was available for review to show an internal pipe inspection was completed in the last five years.</p>	K 0062	<p><b>K 062 NFPA 101 LIFE SAFETY CODE – SprinklerSystems</b></p> <p>1. and 2. No residents were affected but all residents have the potential to be affected by this alleged deficient practice. Elwood Fire Systems performed internal pipe inspection and repair on 5/12/2016 and 5/13/2016.</p> <p>3. The facility's preventative maintenance program was revised to include interior pipe inspection at least every 5 years (See Attachment A).</p> <p>4. Maintenance Supervisor will monitor and document monthly that interior pipe inspection is current as part of the preventative maintenance program. Should a concern be found, immediate corrective action will occur. Results of these reviews will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated.</p>	05/13/2016
K 0066	<p>3.1-19(b)</p> <p>NFPA 101</p>			

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SS=E Bldg. 01	<p><b>LIFE SAFETY CODE STANDARD</b> 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 2 smoking areas were properly maintained and provided with a self-closing trash receptacle used to empty ashtrays only. This deficient practice could affect up to 10 residents using the back exit.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 05/04/16 at 11:00 p.m., in the staff smoking area near the back exit contained a trash can with an open ash</p>	K 0066	<p><b>K 066 NFPA 101 LIFE SAFETY CODE - Smoking</b> 1. and 2. Noresidents were affected but all residents have the potential to be affected bythis alleged deficient practice. The Administratorhas ordered 2 new metal self-closing containers as well as a smoking snufferpole on 5/12/2016. Upon arrival, these items will be placed in the designatedsmoking areas by maintenance supervisor. 3. The facility'spreventative maintenance program has been revised to include proper smokingreceptacles to the weekly monitoring tool (Attachment A). 4. The Maintenance Supervisor</p>	05/20/2016	

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	tray on top. There were about ten cigarette butts in the ash tray and about 10 cigarette butts in the trash can mixed with combustibles. Base on interview at the time of observation, the Maintenance Director acknowledged the cigarette butts and that the smoking area did not have a metal container with a self-closing covered receptacle provided to empty ashtrays or properly dispose of cigarette butts.  3.1-19(b)		will complete the monitoring tool weekly to ensure proper ash trays and ash receptacles are in place. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the plan adjusted if indicated.		