STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	155269		10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST LAKE NURSING & REHABILITATION CENTER	1900 JEANWOOD DR ELKHART, IN 46514

(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
K 0000 Bldg. 01	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). Survey Date: 10/28/15 Facility Number: 000169 Provider Number: 155269 AIM Number: 100267100 At this Life Safety Code survey, East Lake Nursing 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. 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, spaces open to the corridors and battery operated detectors in all resident sleeping rooms. The facility has a capacity of 152 and had a census of 136	K 0000	11/13/15 – To Whom It May Concern: On October 28, 2015 a Life Safety Code Survey was conducted at East Lake Nursing & Rehabilitation. Attached is the plan of correction. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit. Thank you for your time and consideration, Martin Lebbin Executive Director East Lake Nursing and Rehabilitation	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except for the detached shed which provided facility storage and was not sprinklered. Quality Review completed 10/30/15 - DA			
K 0021 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD 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: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 1. Based on observation and interview, the facility failed to ensure 1 of 1 Kitchen doors serving hazardous areas was held open only by a device arranged to automatically close the door or close the door upon activation of the fire alarm system. This deficient practice could affect at least 68 residents in the main dining room which is open to the	K 0021	**K021 – NFPA 101 Life Safety Code Standard** It is the practice of this provider to make sure 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.	11/17/2015

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	corridor. Findings include: Based on observations with the Maintenance Supervisor on 10/28/15 at 1:26 p.m., the kitchen door was held open by a device attached to the wall. Based on interview at the time of observation, the Maintenance Supervisor confirmed that the kitchen door would not release with the fire alarm and acknowledged the aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 6 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect staff and up to 54 residents.		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Director removed the device attached to the wall so the kitchen door cannot be held open. The Maintenance Director removed the wheel chair allowing the fire doors near resident room 402 to close and latch. Residents did not experience any negative outcomes related to the deficient concerns. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The Maintenance Director removed the device attached to the wall so the kitchen door cannot be held open. Kitchen staff will be in-serviced by the Maintenance Director/Designee regarding the necessity to keep the kitchen door closed. The Maintenance Director removed the wheel chair allowing the fire doors near resident room 402 to close and latch. Staff will be in-serviced by the Maintenance Director/Designee regarding the necessity to keep the fire doors clear of any objects. **What measures will be put into place or what systemic changes will**	

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	Findings include: Based on observation with the Maintenance Supervisor on 10/28/15 at 1:50 p.m., the fire doors near resident room 402 failed to close and latch when tested because a wheelchair was in the way. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition and confirmed the set of doors were fire doors. 3.1-19(b)		**be made to ensure that the deficient practice does not recur:** The kitchen door will be monitored to make sure devices are not reattached to hold the door open. The fire doors will be monitored to make sure they are clear of any objects which may prevent them from closing and latching in an emergency. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** To ensure ongoing compliance with this corrective action the Maintenance Supervisor/designee will be responsible for completion of the "Fire Door Closure" audit tool daily for 2 weeks, weekly for 2 weeks, and monthly for six months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Safety Committee for review and follow up. **By what date the systemic chances will be completed:** Compliance date: 11/17/15	
K 0022 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation, the facility failed to ensure 1 of 1 front lobby exit discharge paths was marked with directional	K 0022	**K022 – NFPA 101 Life Safety Code Standard** It is the practice of this provider to	11/13/2015

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	indicators to make the direction of travel to reach the public way obvious. LSC 7.10.1.2 requires exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. LSC 7.10.2 requires a sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. This deficient practice could affect at least 68 residents in the main dining room which shares the front lobby smoke compartment. Findings include: Based on observation with the Maintenance Supervisor on 10/28/15 at 2:59 p.m., one door leading to the front lobby lacked an exit sign. An exit sign was seen through a vision panel next to a door in the corridor. The outside property could be seen through the second vision panel next to the exit sign. Additionally, the facility's floor plan sign was across the hall from the door and indicated the door should be used as an exit door. Based on an interview with the Maintenance Supervisor at the time of observation, the door could be confused for an exit because the outside property		make sure access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Director removed the exit sign that was seen through a vision panel next to a door in the corridor. A "Not an Exit" sign was placed on the corridor door. The facility floor plan sign across the hall was replaced showing the correct exit paths. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The Maintenance Director removed the exit sign that was seen through a vision panel next to a door in the corridor. A "Not an Exit" sign was placed on the corridor door. The facility floor plan sign across the hall was replaced showing the correct exit paths. **What measures will be put into**	

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	and exit sign could be seen through the vision panel in the corridor next to a door. 3.1-19(b)		**place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director removed the exit sign that was seen through a vision panel next to a door in the corridor. A "Not an Exit" sign was placed on the corridor door. The facility floor plan sign across the hall was replaced showing the correct exit paths. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** To ensure ongoing compliance with this corrective action, the Executive Director/Maintenance Director will be responsible for checking the exit sign that was seen through a vision panel next to a door in the corridor was removed. The Executive Director/Maintenance Director will be responsible for checking that "Not an Exit" sign was placed on the corridor door. The Executive Director/Maintenance Director will be responsible for checking that the facility floor plan sign across the hall was replaced showing the correct exit paths. **By what date the systemic changes will be completed:** Compliance date: 11/13/15	
K 0025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD			

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Bldg. 01	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			
	Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were 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 could affect staff only. Findings include: Based on observations with the Maintenance Supervisor on 10/28/15 between 12:06 p.m. to 4:02 p.m., the following unsealed ceiling penetrations were noted: a) the attic access panel was open in the Housekeeping room b) a half inch gap around cables in the Maintenance Room c) a two in gap in conduit around cables and a four inch gap in conduit around wires in the Unit 2 Mechanical Room Based on interview at the time of each	K 0025	**K025 – NFPA 101 Life Safety Code Standard** It is the practice of this provider to make sure smoke barriers are constructed to provide at least a one half hour fire resistance rating. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Supervisor/Designee closed and/or sealed the following identified penetrations: a) The attic access panel was open in the Housekeeping room (Access closed) b) A half inch gap around cables in the Maintenance Room (Gap sealed) c) A two inch gap in conduit around cables and a four inch gap in conduit around wires in the Unit 2 Mechanical Room (Gaps sealed) Residents did not experience any negative outcomes related to the deficient concerns.	11/13/2015

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	observation, the Maintenance Supervisor acknowledged and provided the measurements for each unsealed penetration. 3.1-19(b)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The Maintenance Director closed and/or sealed the following identified penetrations: a) The attic access panel was open in the Housekeeping room (Access closed) b) A half inch gap around cables in the Maintenance Room (Gap sealed) c) A two inch gap in conduit around cables and a four inch gap in conduit around wires in the Unit 2 Mechanical Room (Gaps sealed) **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director closed and/or sealed the following identified penetrations: a) The attic access panel was open in the Housekeeping room (Access closed) b) A half inch gap around cables in the Maintenance Room (Gap sealed) c) A two inch gap in conduit around cables and a four inch gap in conduit around wires in the Unit 2 Mechanical Room (Gaps sealed) The Maintenance Director will request all contractors provide proof that any fire barrier breaches are repaired when they finish a job. All fire barrier sealant will be ASTM E	

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			814 (UL 1479) approved or equivalent. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** To ensure ongoing compliance with this corrective action, the Executive Director/Maintenance Director/designee will be responsible for checking identified areas after construction work/contractors have made changes to make sure any penetrations have been sealed. **By what date the systemic changes will be completed:** Compliance date: 11/13/15	
K 0038 SS=E Bldg. 01	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 Based on observation and interview, the facility failed to ensure 1 of 2 300 Hall exit doors was accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN	K 0038	**K038 – NFPA 101 Life Safety Code Standard** It is the practice of this provider to make sure exit access is arranged so exits are readily accessible at all times. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Director added a sign stating "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN	11/13/2015

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	15 SECONDS " This deficient practice could affect at least 17 residents in the 300 Hall. Findings include: Based on observation with the Maintenance Supervisor on 10/28/15 at 11:40 a.m., the exterior exit door near resident room 311 lacked a sign instructing how to exit. Based on interview at the time of observation, the Maintenance Supervisor confirmed that the door is set up to unlock in 15 seconds and acknowledged there should be a sign.		15 SECONDS" on the exterior exit door near resident room 311. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The Maintenance Director added a sign stating "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" on the exterior exit door near resident room 311. A readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background was placed on the exit door. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director added a sign stating "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" on the exterior exit door near resident room 311. A readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background was placed on the exit door. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what**	

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			quality assurance program will be put into place; To ensure ongoing compliance with this corrective action, the Executive Director/Maintenance Director will be responsible for checking that a sign was added stating "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS " on the exterior exit door near resident room 311. A readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background is on the exit door. **By what date the systemic changes will be completed:** Compliance date: 11/13/15	
K 0050 SS=C Bldg. 01	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 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 3 of 4 quarters. This deficient practice affects all staff and residents.	K 0050	**K050 – NFPA 101 Life Safety Code Standard** It is the practice of this provider to make sure fire drills are held at unexpected times. **What corrective action(s) will be accomplished for those residents**	11/13/2015

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	Findings include: Based on record review of the "Monthly Fire Drill Report" forms with the Maintenance Supervisor on 10/28/15 at 10:57 a.m., three sequential first shift fire drills took place between 1:00 p.m. and 1:30 p.m. for three of the last four quarters. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b) 3.1-51(c)		**found to have been affected by the deficient practice:** The Maintenance Supervisor/designee will stagger quarterly fire drills at unexpected times under varying conditions. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The Maintenance Director will be in serviced regarding the staggering of quarterly fire drills, at unexpected times under varying conditions, by the Clinical Education Coordinator. The Maintenance Supervisor/designee will stagger quarterly fire drills at unexpected times under varying conditions. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Supervisor/designee will stagger quarterly fire drills at unexpected times under varying conditions. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** To ensure ongoing compliance with this corrective action the Maintenance Supervisor/designee will review all fire drills with the	

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			Executive Director/Clinical Education Coordinator to assure quarterly fire drills are staggered at unexpected times under varying conditions. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Safety Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date: 11/13/15	
K 0062 SS=D Bldg. 01	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 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler head in the Freezer was maintained. This deficient practice could affect staff only. Findings include: Based on observations the Maintenance Supervisor on 10/28/15 at 1:30 p.m., the sprinkler head in the walk in freezer had a build up of ice forming an icicle. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)	K 0062	**K062 – NFPA 101 Life Safety Code Standard** It is the practice of this provider to make sure automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Director removed the buildup of ice from the sprinkler head in the walk in freezer. Residents did not experience any negative outcomes related to the	11/17/2015

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			deficient concerns. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The Maintenance Director removed the buildup of ice from the sprinkler head in the walk in freezer. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director removed the buildup of ice from the sprinkler head in the walk in freezer. The sprinkler head in the walk in freezer will be monitored to make sure it is free of any ice buildup. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** To ensure ongoing compliance with this corrective action, the Maintenance Supervisor/designee will be responsible for completion of the “Freezer Sprinkler” audit tool daily for 2 weeks, weekly for 2 weeks, and monthly for six months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Safety Committee for review and	

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			follow up. **By what date the systemic changes will be completed:** Compliance date: 11/17/15	
K 0064 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 1. Based on observation and interview, the facility failed to ensure 1 of 1 200 Hall and 1 of 1 Food Storage fire extinguisher pressure gauge readings was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect staff and up to 24 residents. Findings include: Based on observation with the Maintenance Supervisor on 10/28/15 from 12:02 p.m. then again at 1:44 p.m., the 200 Hall fire extinguisher was under charged. The Activities fire extinguisher was over charged. Based on interview at the time of each observation, the Maintenance Supervisor acknowledged	K 0064	**K064 – NFPA 101 Life Safety Code Standard** It is the practice of this provider to make sure portable fire extinguishers are provided in all health care occupancies. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Supervisor/designee replaced or repaired all deficient fire extinguishers: a) 200 hall fire extinguisher (Fire extinguisher replaced) b) Activities fire extinguisher (Fire extinguisher replaced) c) Unit 1 nurse's station fire extinguisher (Lock from cabinet was removed) d) K class kitchen fire extinguisher (Fire extinguisher replaced) e) Food storage fire extinguisher (Fire extinguisher replaced) Residents did not experience any negative outcomes related to the	11/06/2015

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	each aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguishers in the Unit 1 Nurse's station was readily accessible at all times. NFPA 10, Standard for Portable Fire Extinguishers, Section 1-6.3 requires that fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. This deficient practice could affect staff and up to 17 residents. Findings include: Based on observation with the Maintenance Supervisor on 10/28/15 at 12:27 p.m., the fire extinguisher in the Unit 1 Nurse's station was in locked wall mounted cabinet. Based on interview at the time of observation, Licensed Practical Nurse #1 was asked to unlock the fire extinguisher cabinet. The Licensed Practical Nurse #1 took nine attempts before finally opening the fire extinguisher cabinet. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		deficient concerns. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The Maintenance Supervisor/designee replaced or repaired all deficient fire extinguishers: a) 200 hall fire extinguisher (Fire extinguisher replaced) b) Activities fire extinguisher (Fire extinguisher replaced) c) Unit 1 nurse's station fire extinguisher (Lock from cabinet was removed) d) K class kitchen fire extinguisher (Fire extinguisher replaced) e) Food storage fire extinguisher (Fire extinguisher replaced) **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Supervisor/designee replaced or repaired all deficient fire extinguishers: a) 200 hall fire extinguisher (Fire extinguisher replaced) b) Activities fire extinguisher (Fire extinguisher replaced) c) Unit 1 nurse's station fire extinguisher (Lock from cabinet was removed) d) K class kitchen fire extinguisher	

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	3. Based on observation and interview, the facility failed to ensure 1 of 1 K class kitchen fire extinguishers was maintained as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Supervisor on 10/28/15 at 1:25 p.m., the type K kitchen fire extinguisher was corroded on the nozzle, multiple joints, and was sitting in a pool of green liquid. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b) 4. Based on observation and interview, the facility failed to ensure 1 of 1 Food Storage fire extinguishers requiring a 12-year hydrostatic test was emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect staff only. Findings include: Based on observation and interview on		(Fire extinguisher replaced) e) Food storage fire extinguisher (Fire extinguisher replaced) The Maintenance Director/designee will report any fire extinguishers not meeting the standards to the Safety Committee and replace the fire extinguisher immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** To ensure ongoing compliance with this corrective action, the Maintenance Director/designee will be responsible, during monthly rounds, for completion of the "Non Compliant Fire Extinguisher" audit tool and reporting any fire extinguishers not meeting the standards to the Safety Committee. Any fire extinguishers not meeting the standards will be replaced. **By what date the systemic changes will be completed:** Compliance date: 11/6/15	

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	10/28/15 at 1:31 p.m., the Maintenance Supervisor acknowledged the maintenance tag on fire extinguisher in the Food Storage room indicated the last six year test was completed 05/08. 3.1-19(b)			
K 0069 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 1. Based on record review and interview, the facility failed to ensure 1 of 1 commercial kitchen fire suppression coverage was maintained. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations at 1.3.1 requires cooking equipment shall be maintained per the standard including the fire suppression system during all periods of operation of the cooking equipment. This deficient practice affects staff only. Findings include: Based on observation with the Maintenance Supervisor on 10/28/15 at 1:34 p.m., one of the spray nozzles was being moved and blocked by the "tilt skillet" lid. Based on interview at the time of observation, the Maintenance Supervisor agreed that upon activation,	K 0069	**K069 – NFPA 101 Life Safety Code Standard** It is the practice of this provider to make sure cooking facilities are protected. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Supervisor/designee provided caps and tightened the spray nozzles on the commercial kitchen fire suppression system: a) Spray nozzle by the tilt skillet lid (Inspected nozzle and tightened) b) Kitchen range hood fire suppression system nozzle (Inspected nozzle and replaced blow off cap) Residents did not experience any negative outcomes related to the deficient concerns.	11/06/2015

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	the "tilt skillet" would not be protected and acknowledged the aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 kitchen range hood fire suppression system nozzles were provided with blowoff caps or other suitable devices to prevent the entrance of grease vapors into the nozzles. LSC 9.2.3 requires commercial cooking equipment to be in compliance with NFPA 96, 1998 Edition, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 7-2.2.1 requires automatic fire extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable: a. NFPA 12, Standard on Carbon Dioxide Extinguishing Systems b. NFPA 13, Standard for the Installation of Sprinkler Systems c. NFPA 17, Standard for Dry Chemical Extinguishing Systems d. NFPA 17A, Standard for Wet Chemical Extinguishing Systems NFPA 17A, Standard for Wet Chemical Extinguishing Systems, 1998 Edition, 2-3.1.4 states all discharge nozzles shall		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The Maintenance Supervisor/designee provided caps and tightened the spray nozzles on the commercial kitchen fire suppression system: a) Spray nozzle by the tilt skillet lid (Inspected nozzle and tightened) b) Kitchen range hood fire suppression system nozzle (Inspected nozzle and replaced blow off cap) **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Supervisor/designee provided caps and tightened the spray nozzles on the commercial kitchen fire suppression system: a) Spray nozzle by the tilt skillet lid (Inspected nozzle and tightened) b) Kitchen range hood fire suppression system nozzle (Inspected nozzle and replaced blow off cap) The Maintenance Director will make sure all contractors service and maintain the kitchen fire suppression system according to manufacture guidelines.	

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	be provided with caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign materials into the piping. The protection device shall blow off, open, or blow out upon agent discharge. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Supervisor on 10/28/15 at 1:34 p.m., one of the kitchen range hood fire suppression system nozzles were not provided with a blowoff cap or other suitable devices to prevent the entrance of grease vapors into the nozzles. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** To ensure ongoing compliance with this corrective action, the Maintenance Director/designee will be responsible for checking the blow off caps and adjustments to the commercial kitchen fire suppression system are in compliance. **By what date the systemic changes will be completed:** Compliance date: 11/6/15	
K 0072 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 1. Based on observation and interview, the facility failed to ensure the means of	K 0072	**K072 – NFPA 101 Life Safety Code Standard**	11/17/2015

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	egress for 1 of 2 exits in the 500 Hall and 1 of 2 exits in the 600 Hall were free of all obstructions which could interfere with their full instant use. This deficient practice could affect staff and up to 44 residents. Findings include: Based on observation with the Maintenance Supervisor on 10/28/15 at 2:14 p.m. then again at 2:39 p.m., the 500 exit egress corridor had a bed and mattress stored in the corridor providing four feet four inches of clear width. Then again the 600 exit egress corridor had a motorized cart in the corridor. Based on interview at the time of each observation, the Maintenance Supervisor acknowledged each aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the means of egress for 1 of 1 600 Hall exit corridors was unobstructed. This deficient practice affects staff and at least 22 residents. Findings include: Based on an observation with the Maintenance Supervisor on 10/28/15 at		It is the practice of this provider to make sure egresses are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Director/designee removed the following items: a) 500 exit egress corridor (Removed the mattress) b) 600 exit egress corridor (Removed the motorized cart) c) 600 exit egress corridor (Removed the wheel chairs) Residents did not experience any negative outcomes related to the deficient concerns. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The Maintenance Director/designee removed the following items: a) 500 exit egress corridor (Removed the mattress) b) 600 exit egress corridor (Removed the motorized cart) c) 600 exit egress corridor (Removed	

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	2:29 p.m., two wheelchairs were stored in the corridor side by side near resident room 612 leaving thirty three inches of clear width. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition and provided the measurement. 3.1-19(b)		the wheel chairs) **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director/designee removed the following items: a) 500 exit egress corridor (Removed the mattress) b) 600 exit egress corridor (Removed the motorized cart) c) 600 exit egress corridor (Removed the wheel chairs) The Maintenance Director/designee will provide an in-service for staff regarding the proper clearing of egress corridors. The Maintenance Director/designee will visibly mark egress halls leading to egress doors identifying the proper clearance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** To ensure ongoing compliance with this corrective action, the Maintenance Supervisor/designee will be responsible for completion of the "Egress" audit tool daily for 2 weeks, weekly for 2 weeks, and monthly for six months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Safety Committee	

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			for review and follow up. **By what date the systemic changes will be completed:** Compliance date: 11/17/15	
K 0076 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4			
	Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Supervisor on 10/28/15 at 12:12 p.m., one oxygen cylinder was	K 0076	**K076 – NFPA 101 Life Safety Code Standard** It is the practice of this provider to make sure medical gas storage and administration areas are protected. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Supervisor/designee removed the following item: Unit 1 medication room oxygen cylinder (Moved and stored the cylinder in the proper location) Residents did not experience any negative outcomes related to the deficient concerns. **How other residents having the**	11/17/2015

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	standing up in the Unit 1 Medication Room without support. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The Maintenance Supervisor/designee removed the following item: Unit 1 medication room oxygen cylinder (Moved and stored the cylinder in the proper location) **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Supervisor/designee removed the following item: Unit 1 medication room oxygen cylinder (Moved and stored the cylinder in the proper location) The Maintenance Supervisor/designee will provide an in-service for staff regarding the proper storage of oxygen containers. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** To ensure ongoing compliance with this corrective action, the Maintenance Supervisor/designee will be responsible for completion of the “Oxygen Container” audit tool daily for 2 weeks, weekly for 2	

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			weeks, and monthly for six months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Safety Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date: 11/17/15	
K 0104 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. Based on record review and interview, the facility failed to ensure 6 of 6 fire/smoke dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents in the facility.	K 0104	**K104 – NFPA 101 Life Safety Code Standard** It is the practice of this provider to make sure penetrations of smoke barriers by ducts are protected. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Director immediately contacted East Lake's service vendor to have the 6 fire/smoke dampers inspected. Residents did not experience any negative outcomes related to the deficient concerns. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be	11/04/2015

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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
	Findings include: Based on record review with the Maintenance Supervisor on 10/28/15 at 11:13 a.m., the last inspection for the six dampers in the facility was 11/03/10. Based on an interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		affected by this finding. The Maintenance Director immediately contacted East Lake's service vendor to have the 6 fire/smoke dampers inspected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director immediately contacted East Lake's service vendor to have the 6 fire/smoke dampers inspected. The Maintenance Director will set up a schedule to assure the 6 fire/smoke dampers are inspected according to standards. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** To ensure ongoing compliance with this corrective action, the Maintenance Director/designee will be responsible for maintain the inspection log for the 6 fire/smoke dampers and assuring on-going inspections are according to standards. **By what date the systemic changes will be completed:** Compliance date: 11/4/15	
K 0130 SS=F Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155269	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 10/28/2015
NAME OF PROVIDER OR SUPPLIER EAST LAKE NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 JEANWOOD DR ELKHART, IN 46514	

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	1. Based on observation and interview, the facility failed to ensure the penetration in 1 of 5 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific	K 0130	**K130 – NFPA 101 Miscellaneous** It is the practice of this provider to make sure the penetrations in fire barrier walls are maintained to ensure the fire resistance of the barrier. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Director/designee sealed the following identified penetrations: 1) a) A half inch gap around wires and a one inch gap inside conduit around wires above the drop ceiling by resident room 501. (Gap sealed) b) A half inch penetration around wires, a half inch and a quarter inch gap inside conduit around wires above the drop ceiling by resident room 401. (Penetration sealed) c) A two and one half inch by four inch by six inch brick was missing above the drop ceiling by the Salon. (Penetration sealed) d) A one inch by one and a half inch penetration above the drop ceiling near the Therapy Gym. (Penetration sealed) e) A one inch gap in conduit around wires above the drop ceiling by resident room 202. (Gap sealed) f) A one inch gap in conduit around wires above the drop ceiling by resident room 101. (Gap sealed) g) A one inch gap in conduit around wires and a three and a half	11/13/2015

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	purpose. This deficient practice could affect 44 residents. Findings include: Based on an observation with the Maintenance Supervisor on 10/28/15 between 3:13 p.m. and 4:15 p.m., the following unsealed fire barrier penetrations were discovered: a) a half inch gap around wires and a one inch gap inside conduit around wires above the drop ceiling by resident room 501. Also, a red material and expandable foam was used. b) a half inch penetration around wires, a half inch and a quarter inch gap inside conduit around wires above the drop ceiling by resident room 401. Also, a red material was used. c) a two and one half inch by four inch by six inch brick was missing above the drop ceiling by the Salon. Also, a red material was used. d) a one inch by one and a half inch penetration above the drop ceiling near the Therapy Gym. Also a red material was used. e) one inch gap in conduit around wires above the drop ceiling by resident room 202. Also, a red material was used. f) one inch gap in conduit around wires above the drop ceiling by resident room		inch gap around wires in the attic fire barrier by Therapy. (Gaps sealed) h) A two inch by three inch gap in conduit around wires, a half inch gap around sprinkler pipe, and sixteen inches by forty eight inches of drywall was removed. (Gaps sealed, drywall replaced) 2) One rolling fire door at the opening in the kitchen had its last annual inspection conducted on 04/22/14. (Rolling fire door was inspected and approved) Residents did not experience any negative outcomes related to the deficient concerns. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The Maintenance Director/designee sealed the following identified penetrations: 1) a) A half inch gap around wires and a one inch gap inside conduit around wires above the drop ceiling by resident room 501. (Gap sealed) b) A half inch penetration around wires, a half inch and a quarter inch gap inside conduit around wires above the drop ceiling by resident room 401. (Penetration sealed) c) A two and one half inch by four	

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	101. Also, a red material and expandable foam was used. g) one inch gap in conduit around wires and a three and a half inch gap around wires in the attic fire barrier by Therapy. Also, a red material was used. h) a two inch by three inch gap in conduit around wires, a half inch gap around sprinkler pipe, and sixteen inches by forty eight inches of drywall was removed. Also, a red material was used. Based on interview at the time of each observation, the Maintenance Supervisor was unable to provide documentation on the expandable foam used. The documentation on the red material was for a gasket sealant which lacked information that the product was tested as a though penetration fire stop material meeting ASTM E-814 test requirements. The Maintenance Supervisor acknowledged each aforementioned condition and provided measurements. 3.1-19(b) 2. Based on observation, record review and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors at the opening in the kitchen wall, a hazardous area, was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment, or system required for compliance with this Code shall		inch by six inch brick was missing above the drop ceiling by the Salon. (Penetration sealed) d) A one inch by one and a half inch penetration above the drop ceiling near the Therapy Gym. (Penetration sealed) e) A one inch gap in conduit around wires above the drop ceiling by resident room 202. (Gap sealed) f) A one inch gap in conduit around wires above the drop ceiling by resident room 101. (Gap sealed) g) A one inch gap in conduit around wires and a three and a half inch gap around wires in the attic fire barrier by Therapy. (Gaps sealed) h) A two inch by three inch gap in conduit around wires, a half inch gap around sprinkler pipe, and sixteen inches by forty eight inches of drywall was removed. (Gaps sealed, drywall replaced) 2) One rolling fire door at the opening in the kitchen had its last annual inspection conducted on 04/22/14. (Rolling fire door was inspected and approved) **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director/designee sealed the following identified penetrations: 1) a) A half inch gap around wires and a one inch gap inside conduit	

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	thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect at least 68 residents in the main dining room which is open to the corridor. Findings include: Based on record review with the Maintenance Supervisor on 10/28/15 at 10:37 a.m., the last annual inspection was conducted on 04/22/14. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		around wires above the drop ceiling by resident room 501. (Gap sealed) b) A half inch penetration around wires, a half inch and a quarter inch gap inside conduit around wires above the drop ceiling by resident room 401. (Penetration sealed) c) A two and one half inch by four inch by six inch brick was missing above the drop ceiling by the Salon. (Penetration sealed) d) A one inch by one and a half inch penetration above the drop ceiling near the Therapy Gym. (Penetration sealed) e) A one inch gap in conduit around wires above the drop ceiling by resident room 202. (Gap sealed) f) A one inch gap in conduit around wires above the drop ceiling by resident room 101. (Gap sealed) g) A one inch gap in conduit around wires and a three and a half inch gap around wires in the attic fire barrier by Therapy. (Gaps sealed) h) A two inch by three inch gap in conduit around wires, a half inch gap around sprinkler pipe, and sixteen inches by forty eight inches of drywall was removed. (Gaps sealed, drywall replaced) 2) One rolling fire door at the opening in the kitchen had its last annual inspection conducted on 04/22/14. (Rolling fire door was inspected and approved) The Maintenance Director/designee	

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			will request all contractors provide proof that any fire barrier breaches are repaired when they finish a job. All fire barrier sealant will be ASTM E 814 (UL 1479) approved or equivalent. The Maintenance Director/designee will maintain a record of rolling fire door inspections. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** To ensure ongoing compliance with this corrective action, the Executive Director/Maintenance Director/designee will be responsible for checking identified areas after construction work/contractors have made changes to make sure any penetrations have been sealed. To ensure ongoing compliance with this corrective action, the Maintenance Director/designee will be responsible for maintain the inspection log for the rolling fire doors and assuring on-going inspections are according to standards. **By what date the systemic changes will be completed:** Compliance date: 11/13/15	
K 0143 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:			

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	(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 2 liquid oxygen storage areas where oxygen transferring takes place, was provided with continuous mechanical ventilation. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Supervisor on 10/28/15 at 12:13 p.m., the Unit 1 Nurse's station oxygen storage/transfer room was provided with a mechanically operated fan/vent but was not working. The fan was checked with a strip of tissue. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition.	K 0143	**K143 – NFPA 101 Life Safety Code Standard** It is the practice of this provider to make sure liquid oxygen storage areas, where oxygen transferring takes place, are provided with continuous mechanical ventilation. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Director/designee replaced the following item: Unit 1 Nurse's station oxygen storage/transfer room fan (Fan was replaced) Residents did not experience any negative outcomes related to the deficient concerns. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	11/17/2015

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	3.1-19(b)		**action(s) will be taken:** All residents have the potential to be affected by this finding. The Maintenance Director/designee replaced the following item: Unit 1 Nurse's station oxygen storage/transfer room fan (Fan was replaced) **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director/designee replaced the following item: Unit 1 Nurse's station oxygen storage/transfer room fan (Fan was replaced) **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** To ensure ongoing compliance with this corrective action, the Executive Director/Maintenance Director/designee will be responsible for checking the oxygen storage/transfer room fans, when making monthly fire extinguisher rounds, to make sure they are working properly. Any fans not working properly will be reported to the Safety Committee and repaired/replaced. **By what date the systemic changes will be completed:** Compliance date: 11/17/15	

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K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 multiplug adapter and 16 of 16 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 22 residents. Findings include: Based on observation with Maintenance Supervisor on 10/28/15 between 11:20 a.m. to 3:04 p.m. the following was discovered: a) a surge protector powering a refrigerator in the Business Office b) a surge protector powering a refrigerator in the Payroll Office c) a surge protector powering another surge protector powering a cell phone charger in the Administrator Office d) a surge protector powering a microwave and a refrigerator in the Central Supply room	K 0147	**K147 – NFPA 101 Life Safety Code Standard** It is the practice of this provider to make sure all electrical wiring and equipment is in accordance to the National Electrical Code. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Director/designee removed the following items: a) A surge protector powering a refrigerator in the Business Office (Surge protector removed) b) A surge protector powering a refrigerator in the Payroll Office (Surge protector removed) c) A surge protector powering another surge protector powering a cell phone charger in the Administrator Office (Surge protector removed) d) A surge protector powering a microwave and a refrigerator in the Central Supply room (Surge protector removed) e) A surge protector powering a refrigerator in resident room 205 (Surge protector removed) f) A surge protector powering an oxygen concentrator in resident room 203 (Surge protector removed)	11/13/2015

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	e) a surge protector powering a refrigerator in resident room 205 f) a surge protector powering an oxygen concentrator in resident room 203 g) an extension cord powering a stapler at the Unit 1 Nurse's station h) a surge protector powering a refrigerator in resident room 506 i) a surge protector powering an extension cord powering a television and compressor in the Maintenance Office j) a multiplug adapter powering two separate surge protectors powering phone components in the Unit 2 Mechanical room k) a surge protector powering a coffee pot in the Scheduler's office l) a surge protector powering a coffee pot in the Marketing office. Also, a surge protector powering an extension cord powering computer components Based on interview at the time of observation, the Maintenance Supervisor acknowledged each aforementioned condition. 3.1-19(b)		g) An extension cord powering a stapler at the Unit 1 Nurse's station (Extension cord removed) h) A surge protector powering a refrigerator in resident room 506 (Surge protector removed) i) A surge protector powering an extension cord powering a television and compressor in the Maintenance Office (Surge protector and extension cord removed) j) A multi plug adapter powering two separate surge protectors powering phone components in the Unit 2 Mechanical room (Multi plug adapter and surge protectors removed) k) A surge protector powering a coffee pot in the Scheduler's office (Surge protector removed) l) A surge protector powering a coffee pot in the Marketing office. Also, a surge protector powering an extension cord powering computer components (Surge protectors and extension cord removed) Residents did not experience any negative outcomes related to the deficient concerns. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The Maintenance Director/designee removed the following items:	

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			a) A surge protector powering a refrigerator in the Business Office (Surge protector removed) b) A surge protector powering a refrigerator in the Payroll Office (Surge protector removed) c) A surge protector powering another surge protector powering a cell phone charger in the Administrator Office (Surge protector removed) d) A surge protector powering a microwave and a refrigerator in the Central Supply room (Surge protector removed) e) A surge protector powering a refrigerator in resident room 205 (Surge protector removed) f) A surge protector powering an oxygen concentrator in resident room 203 (Surge protector removed) g) An extension cord powering a stapler at the Unit 1 Nurse's station (Extension cord removed) h) A surge protector powering a refrigerator in resident room 506 (Surge protector removed) i) A surge protector powering an extension cord powering a television and compressor in the Maintenance Office (Surge protector and extension cord removed) j) A multi plug adapter powering two separate surge protectors powering phone components in the Unit 2 Mechanical room (Multi plug adapter and surge protectors removed) k) A surge protector powering a coffee pot in the Scheduler's office	

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			(Surge protector removed) l) A surge protector powering a coffee pot in the Marketing office. Also, a surge protector powering an extension cord powering computer components (Surge protectors and extension cord removed) **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director/designee removed the following items: a) A surge protector powering a refrigerator in the Business Office (Surge protector removed) b) A surge protector powering a refrigerator in the Payroll Office (Surge protector removed) c) A surge protector powering another surge protector powering a cell phone charger in the Administrator Office (Surge protector removed) d) A surge protector powering a microwave and a refrigerator in the Central Supply room (Surge protector removed) e) A surge protector powering a refrigerator in resident room 205 (Surge protector removed) f) A surge protector powering an oxygen concentrator in resident room 203 (Surge protector removed) g) An extension cord powering a stapler at the Unit 1 Nurse's station (Extension cord removed) h) A surge protector powering a refrigerator in resident room 506	

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			(Surge protector removed) i) A surge protector powering an extension cord powering a television and compressor in the Maintenance Office (Surge protector and extension cord removed) j) A multi plug adapter powering two separate surge protectors powering phone components in the Unit 2 Mechanical room (Multi plug adapter and surge protectors removed) k) A surge protector powering a coffee pot in the Scheduler's office (Surge protector removed) l) A surge protector powering a coffee pot in the Marketing office. Also, a surge protector powering an extension cord powering computer components (Surge protectors and extension cord removed) The Maintenance Director/designee will review any utilization of surge protectors for proper low voltage use. The Maintenance Director/designee will review and remove any extension cords. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** To ensure ongoing compliance with this corrective action, the Maintenance Director/designee will be responsible for checking the identified areas to make sure the surge protectors and extension	

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EAST LAKE NURSING & REHABILITATION CENTER	1900 JEANWOOD DR ELKHART, IN 46514

(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
			cords have been removed. New equipment/appliances will need to be reviewed by the Maintenance Director/designee for proper connection to a source of power. Any equipment/appliances not connected properly will be reported to the Safety Committee for review and follow-up. **By what date the systemic changes will be completed:** Compliance date: 11/13/15	