

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155269	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/18/2015
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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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(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	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 10/28/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/18/15</p> <p>Facility Number: 000169 Provider Number: 155269 AIM Number: 100267100</p> <p>At this PSR survey, East Lake Nursing Rehabilitation Center was found in substantial 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, spaces open to the corridors and battery operated detectors in all</p>	K 0000	<p>11/23/15 – To Whom It May Concern: On November 18, 2015 a Life Safety Code Re-Survey was conducted at East Lake Nursing &amp; Rehabilitation. Attached is the plan of correction.</p> <p>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.</p> <p>Thank you for your time and consideration, Martin Lebbin Executive Director East Lake Nursing and Rehabilitation</p>	

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 0130 SS=B Bldg. 01	<p>resident sleeping rooms. The facility has a capacity of 152 and had a census of 140 at the time of this survey.</p> <p>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.</p> <p>Quality Review completed 11/19/15 - DA</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>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</p>	K 0130	<p><b>K130 – NFPA 101 Miscellaneous</b> 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.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>The Maintenance Director/designee sealed the following identified penetration: A one inch gap in conduit around wires above the drop ceiling by resident room 101. (Gap sealed)</p> <p>Residents did not experience any negative outcomes related to the</p>	11/18/2015

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	<p>capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(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:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect at least 15 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 11/18/15 at 3:12 p.m., there was a one inch gap in conduit around wires above the drop ceiling in the fire wall near resident room 101. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition and provided the measurement.</p> <p>This deficiency was cited on 10/28/15. The facility failed to implement a</p>		<p>deficient concern.</p> <p><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:</b></p> <p>All residents have the potential to be affected by this finding.</p> <p>The Maintenance Director/designee sealed the following identified penetration:</p> <p>A one inch gap in conduit around wires above the drop ceiling by resident room 101. (Gap sealed)</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>The Maintenance Director/designee sealed the following identified penetration:</p> <p>A one inch gap in conduit around wires above the drop ceiling by resident room 101. (Gap sealed)</p> <p>The Maintenance Director/designee 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.</p> <p><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;</b></p> <p>To ensure ongoing compliance with</p>				

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	systemic plan of correction to prevent recurrence.  3.1-19(b)		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. <b>By what date the systemic changes will be completed:</b> Compliance date: 11/18/15		