

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/14/2014
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NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
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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
K010000	<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: 04/14/14</p> <p>Facility Number: 012329 Provider Number: 155784 AIM Number: 201002500</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist.</p> <p>At this Life Safety Code survey, Michiana Health 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 18, New Health Care Occupancies.</p> <p>This one story facility built in 2010 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 and in spaces open to the corridors with hard wired smoke detectors in all the resident sleeping rooms. The facility has a capacity of 100 and had a census of 81 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for an eight by ten foot wood shed used for</p>	K010000	Michiana Health and Rehabilitation respectfully requests a desk review and approval of the following 2567.	

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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K010066 SS=D	<p>storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/17/14.</p> <p>This facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: NFPA 101 LIFE SAFETY CODE STANDARD 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. 18.7.4</p> <p>Based on observation and interview, the facility failed to enforce a no smoking policy and ensure cigarette butts were deposited into a noncombustible container in 1 of 1 areas where smoking was obvious. This deficient practice would not have directly</p>	K010066	<p>K 066</p> <p>It is the practice of this facility to have a written plan designating the smoking policy for the facility. CORRECTIVE ACTION: Appropriate signage has been placed in area around generator identifying the area as a hazardous location /</p>	05/14/2014

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K010130 SS=D	<p>affected residents but could affect staff utilizing the employee entrance.</p> <p>Findings include:</p> <p>Based on interview on 04/14/14 with the Maintenance Director from 11:15 a.m. to 1:00 p.m., the facility is a "no smoking campus." Based on observation from 1:00 p.m. to 2:00 p.m., the ground around the concrete parking area adjacent to the emergency generator and employee entrance was littered with cigarette butts. The Maintenance Director acknowledged the facility staff disposed of cigarette butts on the ground at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 battery operated emergency lights in the facility was maintained. LSC section 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice would not directly affect any resident but could affect staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director from 1:00 p.m. to 2:00 p.m. on 04/14/14, the battery operated emergency light above the generator transfer switch was</p>	K010130	<p>combustible gases.</p> <p>HOW OTHERS IDENTIFIED: Placing the posting will address all residents residing in the facility.</p> <p>PREVENTATIVE MEASURES: 1) All staff will be in-serviced regarding the smoking policy for the facility 2) Appropriate noncombustible containers will be maintained in smoking area.</p> <p>MOINTORING: Maintenance Director will inspect weekly all Hazardous areas for signs of smoking. All findings will be reviewed at monthly QPI meetings COMPLETION DATE: 5/14/2014</p> <p>It is the practice of this facility to ensure that all emergency equipment operates correctly in the event of an emergency or evacuation of the facility.</p> <p>CORRECTIVE ACTION: The battery operated emergency lights in the facility have been inspected and all batteries replaced.</p> <p>HOW OTHERS IDENTIFIED: Replacing the batteries will address all residents residing in the facility.</p> <p>PREVENTATIVE MEASURES: The batteries will be replaced at</p>	05/14/2014

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K010144 SS=F	<p>not functional when tested. Based on interview at the time of observation, the Maintenance Director acknowledged the battery operated emergency light above the generator transfer switch did not function when tested.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to exercise 1 of 1 generators to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a</p>	K010144	<p>least annually or sooner as indicated by monthly testing of battery operated emergency lighting. MONITORING: Maintenance Director will monitor the operation of the battery operated emergency lighting monthly. Battery Operated Emergency Lighting log will be completed monthly and maintained indefinitely. All findings will be reviewed at monthly QPI meeting. COMPLETION DATE: 5/14/2014</p> <p>K144 It is the practice of this facility to ensure that the generator is inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. CORRECTIVE ACTION: 1) Generator logs are being kept related to the correct starting and inspection. 2) Monthly generator load test is being conducted and recorded. Logs maintained regarding results. HOW OTHERS IDENTIFIED: Correcting the above areas will address all residents residing in facility.</p>	05/14/2014	

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	<p>minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of emergency generator monthly load testing documentation with the Maintenance Director on 04/14/14 at 1:00 p.m., monthly generator load tests were not documented for April, June, September and November of 2013. For the remaining eight months, the electronic logbook documentation for generator load testing indicated the "Name Plate KVA", "30 % Name Plate Rating", "Amps: L1+L2+L3=", "Total Amps" and the "Avg Amps X Volts X 1.732 (for 3 Phase)/1000 = " fields as all being 0 (zero). Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned conditions regarding generator documentation.</p> <p>3.1-19(b)</p>		<p>PREVENTATIVE MEASURES: Maintenance Director to monitor the preventative maintenance log for the completion of the above areas.</p> <p>MONITORING: Generator log will be completed by Maintenance Director weekly indefinitely. Generator load test will be completed monthly indefinitely. All Findings will be reviewed at monthly QPI meeting. COMPLETION DATE: 5/14/2014</p>		