

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155449	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2011
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NAME OF PROVIDER OR SUPPLIER NORTHERN LAKES NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 516 N WILLIAMS ST ANGOLA, IN46703
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/17/11</p> <p>Facility Number: 000426 Provider Number: 155449 AIM Number: 100275480</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Northern Lakes Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000)</p>	K0000	<p>Submission of this response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency, was correctly cited, and is not to be construed as an admission of interest against the facility, the administrator, or any employees, agents or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Included is the Plan of Correction for our annual Life Safety Recertification and State Licensure Survey for Northern Lakes Nursing & Rehabilitation Center. The Plan of Correction is also to serve as our Credible Allegation of Compliance.</p>	

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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K0021 SS=E	<p>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridors. The facility has a capacity of 150 and had a census of 81 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/21/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>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:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure one door of 1 of 6 sets of</p>	K0021	K021 All staff have been re-educated on (see attached) Fire Safety including keeping smoke barrier doors free of	11/16/2011

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K0025 SS=F	<p>smoke barrier doors would close once the fire alarm system is activated. This deficient practice could affect any of the nineteen residents on Sandy Shore and at the back hall nurses' station.</p> <p>Finding include:</p> <p>Based on observation with the Maintenance Supervisor on 10/17/11 at 2:05 p.m., one of the smoke barrier doors on Sandy Shore did release upon activation of the fire alarm but was held in the open position by a medication cart. This was confirmed by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on observation and</p>	K0025	<p>obstructions that may hinder the doors from closing properly. All doors were immediately checked to ensure no further issues existed with this practice. Maintenance staff has updated the daily Preventative Maintenance Schedule (see attached) that includes monitoring of fire doors daily, maintenance staff has been educated (see attached) on monitoring smoke barrier doors. All department managers have been instructed to monitor smoke barrier doors during daily rounds. Quality Assurance will receive reports from maintenance director and other department managers on continued compliance with this tag at monthly meetings for 3 months and if continued compliance is maintained, will be reviewed quarterly there after. (see attached QA Schedule)</p> <p>K 025 The facility has received</p>	11/25/2011			

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	<p>interview, the facility fail to ensure 4 of 4 duct penetrations through smoke barrier walls were provided with a smoke damper. This deficient practice could affect all residents because these smoke barrier walls were in the resident room halls.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 10/17/11 at 1:50 p.m. to 2:00 p.m., smoke dampers were not installed on the four ventilation ducts that penetrated the smoke barrier wall on the Sandy Shores, Island Park, Piers and Coves halls. Based on interview with the Maintenance Supervisor at 1:50 p.m. on 10/17/11, the ventilation system does not shut down upon activation of the fire alarm.</p> <p>3.1-19(b)</p>		<p>bids and has signed contracts to have installed smoke dampers (see attached) on the four ventilation ducts including Sandy Shores, Island Park, Coves, and Piers. This work is scheduled to be completed on or before November 23, 2011. Maintenance Director did inspect all ventilation ducts to ensure all areas had been identified. After installation of dampers Simplex Grinnell will add an inspection of dampers to be completed according to Life Safety requirements. During the time that we do not have the dampers installed we have instructed maintenance staff, department managers, and nurses (see attached) that if the facility experiences a fire we are to shut the furnaces down using the outside power source thus not allowing any smoke to travel thru our ventilation system. In addition, we have posted instruction sheets at each fire alarm station, and instruction signs for killing power by the outside power source so we can assure that this is followed correctly. Simplex Grinnell inspections will be reviewed at our scheduled Quality Assurance Meetings to ensure compliance. The facility respectfully requests that we be given an extension on our plan of correction compliance date to November 25, 2011.</p>		

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K0056 SS=E	<p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure complete automatic sprinkler system was provided for 2 of 2 building overhangs in accordance with NFPA 13, Standard for Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect any resident evacuated through the Island Park and the Sandy Shore exits in the event of an emergency.</p> <p>Findings include:</p>	K0056	<p>K 0056 The facility has received bids and has signed contract (see attached) to have installed two sprinkler heads on Island Park and Sandy Shores north and south exit canopies. This work is scheduled to be completed on November 10, 2011. Maintenance Director has inspected all exit canopies to ensure no further issues were noted.</p>	11/16/2011	

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K0074 SS=B	<p>Based on an observation with the Maintenance Supervisor on 10/17/11 from 1:10 p.m. to 1:15 p.m., there were nonsprinklered combustible overhangs measuring five feet four inches at the Island Park and the Sandy Shore exits. Measurements were provided by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 4 of 35 occupied resident rooms and 1 of</p>	K0074	K 0074 All draperies that we do not have proof of fire rating have been removed from facility. The Maintenance Director and Environmental Director did	11/16/2011	

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	<p>1 beauty shop were flame retardant. This deficient practice could affect 8 of 81 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 10/17/11 from 12:45 p.m. to 2:05 p.m., the window curtains in resident rooms number 18, 43, 45, 49 and the beauty shop lacked a tag confirming they were inherently flame retardant. Based on interview with the Maintenance Supervisor at 12:45 p.m., there was no documentation available for review regarding flame retardancy for these window coverings.</p> <p>3.1-19(b)</p>		<p>inspect the entire facility for any further issues with our drapes. We have sent letter to all resident families/responsible parties (see attached) informing them of fire rating on drapes, and ask that they bring any future drapes to maintenance or environmental directors to be inspected for compliance before installation.</p>		