

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155596	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2014
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NAME OF PROVIDER OR SUPPLIER LAKELAND SKILLED NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703
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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: 08/25/14</p> <p>Facility Number: 000474 Provider Number: 155596 AIM Number: 100290510</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Lakeland Skilled Nursing and Rehabilitation 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) and 410 IAC 16.2. The original building consisting of the 200, 300 halls and the service hall was surveyed with Chapter 19, Existing Health Care Occupancies.</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</p>	K010000	<p>This Plan of Correction is the centers credible allegation of compliance.</p> <p>Preparation and /or execution of this plan of correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K010018 SS=E	<p>corridors and areas open to the corridors. The resident rooms on the 300 hall and 400 hall had hard wired smoke detectors. The resident rooms on the 200 hall had battery operated smoke detectors. The facility has a capacity of 75 and had a census of 73 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had a detached shed providing facility services including maintenance supplies that was not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 08/29/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are</p>				

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K010025 SS=E	<p>permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure there were no impediments to the closing of 2 of 42 resident room doors protecting corridor openings. This deficient practice could affect 2 of 7 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 08/25/14 at 12:12 p.m., the corridor doors to resident room 203 was obstructed by a bed mat located on the floor and at 1:15 p.m., the corridor door to resident room 400 was obstructed by a chair. This was acknowledged by the Maintenance Supervisor.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p>	K010018	<p>K018 - Both the bed mat in room 203 and the chair in room 400 were relocated on 8-25-14 so as not to obstruct the corridor doors.</p> <p>Staff were re-educated throughout the week of 9-2-14 on corridor doors not to be obstructed.</p> <p>Corridor doors being unobstructed were added to Department Directors daily rounds.</p> <p>Daily rounds are handed in to and reviewed for compliance by the Administrator. Administrator will present these to the Business Leadership Team on a weekly basis for four weeks. If there are no further issues noted, then the rounds will be presented to the Quality Assurance Committee on a monthly basis for five months.</p>	09/24/2014			

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	<p>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 interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was 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 2 of 7 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 08/25/14 the following was noted:</p> <p>a) at 11:42 a.m. and then at 12:05 p.m., there was a one fourth inch gap alongside the sprinkler head in the conference room and the 200 hall oxygen supply room closet</p> <p>b) at 2:07 p.m., the 200 hall attic access panel was one layer of five eights inch drywall. Based on interview with the Maintenance Supervisor, the ceiling throughout the facility has two layers of 5/8 inch drywall.</p> <p>c) at 2:13 p.m., above the ceiling tile at the 400 hall fire door, there were two sections of ceiling drywall measuring 12 inches by 24 inches cut out to allow the four inch sprinkler pipe to continue into the 400 hall addition. The gaps around</p>	K010025	<p>K025</p> <p>a). Both of the ¼ inch gaps alongside the sprinkler heads, one in the conference room and one in the 200 hall oxygen supply room, were fixed by 9-5-14.</p> <p>b). The 200 hall attic access panel had another layer of 5/8 inch drywall added to it on 9-5-14.</p> <p>c). The two sections of ceiling drywall around the four inch sprinkler pipe going to the 400 hall were enclosed on 9-9-14</p> <p>Weekly inspections of the fire walls will be made by the Maintenance Director. Any further gaps found will be fixed immediately. All weekly inspections will be presented to and reviewed by the Business Leadership Team on a weekly basis for 4 weeks. If no further issues are presented, the Business Leadership Teams, responsible to the Administrator, will then review on a monthly basis for five months.</p>	09/24/2014

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K010048 SS=C	<p>the sprinkler lines had not been filled and sealed. Measurements were provided by Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written plan that included the evacuation of smoke compartments and response to battery operated smoke detectors in the resident rooms in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants.</p>	K010048	<p>K048 - The Disaster Plan was reviewed and revised 8-27-14 to include a.) horizontal evacuation, moving residents from one smoke compartment to another and b.) a policy for battery operated smoke detectors.</p> <p>Staff were re-educated on the updates to the disaster plan throughout the week of 9-2-14.</p> <p>The response to all smoke detectors whether battery or not was added to the fire drill procedure and will be discussed at each fire drill.</p> <p>The completed fire drill documentation will be presented by the Maintenance Director on a monthly basis to the Business Leadership Team for three months. The Business Leadership Team will submit the results of the fire drills to the Quality Assurance committee,</p>	09/24/2014

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K010050 SS=C	<p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor on 08/25/14 at 11:25 a.m., the "Disaster Plan" did not address evacuation of smoke compartment and activation of a battery operated smoke detector in the resident rooms. This was confirmed by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p>	K010050	<p>responsible to the Administrator, on a quarterly basis for 2 quarters for review of continued compliance.</p> <p>K050 – A calendar was established with the date and time of the fire drill.</p> <p>Maintenance Director or his designee is responsible for carrying out the fire drill procedures on the date and at the time established.</p>	09/24/2014

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K010062 SS=D	<p>Based on record review of the "Fire/Severe Weather/Evacuation Drill Report" forms with Maintenance Supervisor on 08/25/14 at 10:57 a.m., 3 of 4 first shift fire drills took place between 10:15 a.m. and 11:15 a.m. for the past four quarters on 06/20/14, 11:00 a.m., 09/30/13, 10:15 a.m. and 12/27/13, 10:45 a.m. All second shift fire drills took place between 2:15 p.m. and 2:30 p.m. for the last four quarters on 07/23/14, 2:15 p.m., 04/24/14, 2:30 p.m., 01/29/14, 2:15 p.m. and 10/28/13, 2:30 p.m. This was confirmed by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace the loaded sprinkler head in 1 of 1 closets in resident room 202. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of</p>	K010062	<p>All fire drills will be submitted by the Maintenance Director to the Business Leadership Team on a monthly basis for review of compliance. Business Leadership Team will submit to the Quality Assurance Committee, responsible to the Administrator, on a quarterly basis for review of continued compliance.</p> <p>K062 – The sprinkler head with paint on it in room 202 was replaced on 9- 9-14.</p> <p>An audit was completed on all sprinklers on 9-5-14. Any sprinklers with any paint were replaced on 9-9-14.</p>	09/24/2014			

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K010070 SS=D	<p>Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 2 residents in resident room 202.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 08/25/14 at 12:08 p.m., there was a buildup of paint on the sprinkler head in the closet of resident room 202. The Maintenance Supervisor acknowledged there was paint on the sprinkler head in closet of resident room 202 at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and record review, the facility failed to enforce the policy for the use of 1 of 1 portable space heaters in the facility in accordance with NFPA</p>	K010070	<p>An audit of sprinkler heads will be completed on a monthly basis for the next six months and an inspection will be completed immediately of sprinkler heads in area's that are being painted.</p> <p>Maintenance Director will submit the monthly audit to the Business Leadership Team on a monthly basis for review of continued compliance. The Business Leadership Team will submit the audits to the Quality Assurance Committee, responsible to the Administrator, on a quarterly basis for continued compliance for the next two quarters.</p> <p>K070 – The space heater was removed from the facility on 8-25-14.</p>	09/24/2014			

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K010130 SS=E	<p>101, Section 19.7.8. This deficient practice is not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 08/25/14 at 11:52 a.m., there was a space heater in the Social Services's office. Based on record review with the Maintenance Supervisor on 08/25/14 at 11:00 a.m., the facility does not allow space heaters.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in 3 of 4 fire barrier walls were 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</p>	K010130	<p>The policy was reviewed and revised on 8-28-14. Staff were re-educated on the policy throughout the week of 9-2-14. Prohibited electrical items were also added to the daily round performed by Department Heads. The daily rounds are submitted to and reviewed by the Administrator. The Administrator will submit the rounds weekly for four weeks to the Business Leadership Team for review of compliance. If there are no further compliance issues, the Business Leadership Team will submit the rounds to the Quality Assurance committee, responsible to the Administrator, on a monthly basis for the next six months, for review of compliance.</p> <p>K130 - The following corrections were made to the penetrations of the fire wall, a.) above the ceiling tile at the 200 Hall and 300 hall fire wall penetrations were resealed with fire caulking.</p> <p>b.) the attic at the 400 hall fire barrier wall where there were two penetrations sited were resealed with fire caulking.</p> <p>An audit was conducted on 9-8-14 for any further issues. A weekly inspection will be</p>	09/24/2014			

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	<p>protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one 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>(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 residents in 4 of 7 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 08/25/14 from 2:00 p.m. to 2:13 p.m., the following fire wall penetrations were noted:</p> <p>a) above the ceiling tile at the 200 hall and 300 hall fire barrier doors there were penetrations sealed with a putty type</p>		<p>completed by the Maintenance Director for penetrations of the fire barrier walls. The weekly inspections will be submitted by the Maintenance Director to the Business Leadership Team on a weekly basis for four weeks for review of compliance. The Business Leadership Team will submit the findings from the inspections to the Quality Assurance Committee, responsible to the Administrator on a monthly basis for the next six months for review of continued compliance.</p>	

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K010143 SS=E	<p>substance that had shrunk away or could be pulled away from the penetrations. Based on an interview with the Maintenance Supervisor at the time of observations, he was unable to identify the putty substance nor confirm to was fire resistant</p> <p>b) in the attic at the 400 hall fire barrier wall there were unsealed penetration ranging in size from one inch around an electrical wire to one half inch around a pipe. The Maintenance Supervisor confirmed the aforementioned wall were fire barrier walls and provided the measurements at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(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;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p>			

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	<p>(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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was provided with continuous mechanical ventilation and was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. . This deficient practice could affect 1 of 7 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation and interview with the Maintenance Supervisor on 08/25/14 at 1:35 p.m., he stated the mechanical ventilation in the oxygen transfilling/storage was not working. The room was completely full of large stationary containers of liquid oxygen. The LPN #1 was asked to demonstration filling a small portable unit from a stationary container of liquid oxygen and she did so with the door open stating due to the number of large stationary containers of liquid oxygen she could not get in the room and close the door.</p> <p>3.1-19(b)</p>	K010143	<p>K143</p> <p>The mechanical ventilation was replaced on 8-26-14. Mechanical ventilation is on a weekly check list.</p> <p>Excess canister were removed on 8-28-14 so that the door could be closed when filling portable concentrators. An audit will be completed by the DON, ADON or her designee, after each delivery to make sure there are not an excess of canisters and that the door can be properly closed during dispensing of oxygen.</p> <p>The audits will be submitted to the Business Leadership Team on a weekly basis for four weeks, for review of compliance. If there are no further issues they will then be submitted monthly. The Business Leadership Team will submit the results of the audits to the Quality Assurance Committee, responsible to the Administrator, for compliance review on a monthly basis for the next six months.</p>	09/24/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155596	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2014
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NAME OF PROVIDER OR SUPPLIER LAKELAND SKILLED NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703
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K010144 SS=F	<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 ensure the load testing for the past 12 of 12 months indicated a load test was conducted under operating temperature conditions, minimum exhaust gas temperatures or not less than 30 percent of the nameplate rating for the diesel powered emergency generator set. 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, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating temperature conditions, maintains the minimum exhaust gas temperatures as recommended by the manufacturer or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period and repairs for the generator to be regularly</p>	K010144	<p>K144</p> <p>The Maintenance Director confirmed with Cummins Generators that the generator needed to have a Low bank test annually. This was conducted on 9-5-14 and will be placed on the annual generator test list. Maintenance is responsible for scheduling and documenting that the annual tests are completed. Copies of all annual tests will be submitted to the Quality Assurance Committee, responsible to the Administrator, to review for compliance.</p>	09/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155596		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2014	
NAME OF PROVIDER OR SUPPLIER LAKELAND SKILLED NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703			
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K010147 SS=E	<p>maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all resident in the facility.</p> <p>Findings include:</p> <p>Based on record review and interview with the Maintenance Supervisor of the "Emergency Generator Checklist" and an additional untitled form on 08/25/14 at 11:36 a.m., the generator test log showed an exhaust temperature for every monthly load test but the Maintenance Supervisor was unable to confirm if the documented temperatures were the minimum required by the manufacturer. He stated he uses a hand held infrared gun to take the temperatures. There was no documentation on the generator log to verify the generator was tested under operating temperature conditions or at least 30 percent of the EPS nameplate rating.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 1. Based on observation and interview, the facility failed to ensure 2 of 2 flexible</p>	K010147	K147	09/24/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155596		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2014	
NAME OF PROVIDER OR SUPPLIER LAKELAND SKILLED NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703			
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	<p>cords such as an extension cord were not used as a substitute for fixed wiring or to provide power equipment with a high current draw. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 2 residents in resident room 414 and residents in the Beauty Shop.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 08/25/14, the following was noted:</p> <p>a) at 12:50 p.m., a regular light weight extension cord was plugged in and providing power for the light and a cell phone charger in resident room 414</p> <p>b) at 1:20 p.m., a power strip was providing power for two hair dryers and two curling irons in the Beauty Shop This was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview,</p>		<p>1. The extension cord was removed from room 414 on 8-25-14. An audit was conducted on 8-26-14 and any prohibited electrical items removed. The power strip was removed from the Beauty shop and will not be used in the future.</p> <p>2. A junction box was installed on 9-8-14, where the exposed wire was found at the 300 hall fire wall.</p> <p>The policy for prohibited electrical items was reviewed and revised 8-28-14.</p> <p>Staff were re-educated on the policy/procedure throughout the week of 9-2-14.</p> <p>Daily round list for Department Directors was updated to include prohibited electrical items.</p> <p>Round sheets are turned in to the Administrator for review on a weekly basis. The Administrator will review the rounds and submit the results to the Business Leadership Team on a weekly basis for four weeks. If there are no further incidents, the Administrator will submit the results of the daily rounds to the Quality Assurance Committee on a monthly basis for the next six months to review for continued compliance</p>				

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NAME OF PROVIDER OR SUPPLIER LAKELAND SKILLED NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703
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K030000	<p>the facility failed to provide a junction box for 1 of 1 exposed electrical wiring at the 300 hall fire wall barrier wall. NFPA 70, National Electrical Code, 1999 Edition, Article 370-28(c) requires exposed electrical wires be confined within a junction box with a cover compatible with the box. This deficient practice was not in a resident care area but could affect maintenance staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 08/25/14 at 2:10 p.m., above the ceiling tile at the 300 hall fire barrier wall there was a small section of electrical wire that penetrated the fire barrier wall and was wrapped in a coil with bare wires at the end. Based on an interview with the Maintenance Supervisor at the time of observation, he didn't know the origin of the electrical wire nor why it was there.</p> <p>3.1-19(b)</p> <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>	K030000	<p>This Plan of Correction is the centers credible allegation of compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155596	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2014
NAME OF PROVIDER OR SUPPLIER LAKELAND SKILLED NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703		
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	<p>Survey Date: 08/25/14</p> <p>Facility Number: 000474 Provider Number: 155596 AIM Number: 100290510</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Lakeland Skilled Nursing and Rehabilitation 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) and 410 IAC 16.2. The new 2012 addition of the 400 hall was surveyed with Chapter 18, New Health Care Occupancies.</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 and areas open to the corridors. The resident rooms on the 300 hall and 400 hall had hard wired smoke detectors. The resident rooms on the 200 hall had battery operated smoke detectors. The facility has a capacity of 75 and had a census of 73 at the time of this survey.</p>		<p>Preparation and /or execution of this plan of correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>		

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NAME OF PROVIDER OR SUPPLIER LAKELAND SKILLED NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703
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K030048 SS=C	<p>All areas where the residents have customary access were sprinklered. The facility had a detached shed providing facility services including maintenance supplies that was not sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 Based on record review and interview, the facility failed to provide a written plan that included the evacuation of smoke compartments in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all</p>	K030048	<p>K048 - The Disaster Plan was reviewed and revised 8-27-14 to include a.) horizontal evacuation, moving residents from one smoke compartment to another and b.) a policy for battery operated smoke detectors.</p> <p>Staff were re-educated on the updates to the disaster plan throughout the week of 9-2-14.</p> <p>The response to all smoke detectors whether battery or not was added to the fire drill procedure and will be discussed at each fire drill.</p> <p>The completed fire drill documentation will be presented by the Maintenance Director on a monthly basis to the Business Leadership Team for three</p>	09/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155596		X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2014	
NAME OF PROVIDER OR SUPPLIER LAKELAND SKILLED NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703			
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K030050 SS=C	<p>occupants.</p> <p>Findings include:</p> <p>Based on a record review with the Maintenance Supervisor on 08/25/14 at 11:25 a.m., the "Disaster Plan" did not address evacuation of smoke compartment. This was confirmed by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b)</p> <p>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. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Fire/Severe Weather/Evacuation Drill</p>	K030050	<p>months. The Business Leadership Team will submit the results of the fire drills to the Quality Assurance committee, responsible to the Administrator, on a quarterly basis for 2 quarters for review of continued compliance.</p> <p>K050 – A calendar was established with the date and time of the fire drill.</p> <p>Maintenance Director or his designee is responsible for carrying out the fire drill procedures on the date and at the time established.</p> <p>All fire drills will be submitted by</p>	09/24/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155596		X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2014	
NAME OF PROVIDER OR SUPPLIER LAKELAND SKILLED NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703			
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K030130 SS=E	<p>Report" forms with Maintenance Supervisor on 08/25/14 at 10:57 a.m., 3 of 4 first shift fire drills took place between 10:15 a.m. and 11:15 a.m. for the past four quarters on 06/20/14, 11:00 a.m., 09/30/13, 10:15 a.m. and 12/27/13, 10:45 a.m. All second shift fire drills took place between 2:15 p.m. and 2:30 p.m. for the last four quarters on 07/23/14, 2:15 p.m., 04/24/14, 2:30 p.m., 01/29/14, 2:15 p.m. and 10/28/13, 2:30 p.m. This was confirmed by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 fire barrier walls on the 400 hall 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</p>	K030130	<p>the Maintenance Director to the Business Leadership Team on a monthly basis for review of compliance. Business Leadership Team will submit to the Quality Assurance Committee, responsible to the Administrator, on a quarterly basis for review of continued compliance.</p> <p>K130 - The following corrections were made to the penetrations of the fire wall, a.) above the ceiling tile at the 200 Hall and 300 hall fire wall penetrations were resealed with fire caulking.</p> <p>b.) the attic at the 400 hall fire barrier wall where there were two penetrations sited were resealed with fire caulking.</p> <p>An audit was conducted on 9-8-14 for any further issues. A weekly inspection will be</p>	09/24/2014			

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NAME OF PROVIDER OR SUPPLIER LAKELAND SKILLED NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703			
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	<p>barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one 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>(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 residents in 1 of 2 smoke compartments in the 400 hall.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 08/25/14 at 2:13 p.m., in the attic at the 400 hall fire barrier wall there were unsealed penetration ranging in size from one inch around a electrical wire to one half inch</p>		<p>completed by the Maintenance Director for penetrations of the fire barrier walls. The weekly inspections will be submitted by the Maintenance Director to the Business Leadership Team on a weekly basis for four weeks for review of compliance. The Business Leadership Team will submit the findings from the inspections to the Quality Assurance Committee, responsible to the Administrator on a monthly basis for the next six months for review of continued compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155596	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2014
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NAME OF PROVIDER OR SUPPLIER LAKELAND SKILLED NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703
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K030144 SS=F	<p>around a pipe. The Maintenance Supervisor confirmed the 400 hall fire barrier wall and provided the measurements at the time of observations.</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 ensure the load testing for the past 12 of 12 months indicated a load test was conducted under operating temperature conditions, minimum exhaust gas temperatures or not less than 30 percent of the nameplate rating for the diesel powered emergency generator set. 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, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating temperature conditions, maintains the minimum exhaust gas temperatures as recommended by the manufacturer or not less than 30 percent</p>	K030144	<p>K144</p> <p>The Maintenance Director confirmed with Cummins Generators that the generator needed to have a Low bank test annually. This was conducted on 9-5-14 and will be placed on the annual generator test list. Maintenance is responsible for scheduling and documenting that the annual tests are completed. Copies of all annual tests will be submitted to the Quality Assurance Committee, responsible to the Administrator, to review for compliance.</p>	09/24/2014

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	<p>of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all resident in the facility.</p> <p>Findings include:</p> <p>Based on record review and interview with the Maintenance Supervisor of the "Emergency Generator Checklist" and an additional untitled form on 08/25/14 at 11:36 a.m., the generator test log showed an exhaust temperature for every monthly load test but the Maintenance Supervisor was unable to confirm if the temperatures were the minimum required by the manufacturer. He stated he uses a hand held infrared gun to take the temperatures. There was no documentation on the generator log to verify the generator was tested under operating temperature conditions or at least 30 percent of the EPS nameplate rating.</p> <p>3.1-19(b)</p>						