

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/01/2011
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NAME OF PROVIDER OR SUPPLIER  LAKELAND REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN46542
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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: 11/01/11</p> <p>Facility Number: 000491 Provider Number: 155495 AIM Number: 100291230</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Lakeland Rehabilitation and Healthcare 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>This plan of correction is submitted by Lakeland Rehabilitation and Healthcare Center in order to respond to the alleged deficiencies sited during our Life Safety Code Survey which was conducted on November 1, 2011. Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of Federal and State law. Please accept this plan of correction as the provider's credible allegation of compliance effective December 1, 2011.</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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K0025 SS=E	<p>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 facility has a capacity of 60 and had a census of 52 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/04/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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 interview, the facility failed to ensure 5 of 5 penetrations caused by the passage of wire and/or conduit through a smoke barrier wall were protected to maintain</p>	K0025	No residents were affected by deficient practice. The five unsealed penetrations ranging in size from one inch around a main sprinkler line to one fourth inch around conduit were filled with a material capable of maintaining the smoke resistance of the	12/01/2011

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	<p>the smoke resistance of the smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect two of four smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 11/01/11 at 2:11 p.m., the attic center core smoke barrier wall had five unsealed penetrations ranging in size from one inch around a main sprinkler line to one fourth inch around conduit. Additionally, an access was cut out of the smoke barrier wall measuring two feet by three feet. The drywall access panel cover had been</p>		<p>smoke barrier. The drywall access panel cover was replaced with a fire rated access panel door.1. Plant Ops Director will be inserviced on importance of maintaining smoke barriers by Plant Ops Home office support/Designee.2. Plant Ops Director/Designee will audit 2x weekly for above mentioned access panel door in place for one month and then audit monthly thereafter.3. Any non-compliance issues will be addressed immediately and staff responsible will be re-educated/disciplined as appropriate per facility disciplinary policy.Plant Ops Director/Designee will bring all audits to the QA Committee for review x 6 months, and then quarterly thereafter until 100% compliance is achieved.Date of Compliance: December 1, 2011</p>	

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	<p>placed to the side. Based on an interview with the Director of Plant Operations at the time of observation, he ran a computer line the previous evening and removed the access panel to enter the adjacent smoke compartment. At this time the Director of Plant Operations returned the access cover to the original position. The cover did not fit properly creating a one half inch gap at the bottom where various wires ran through the opening.</p> <p>3.1-19(b)</p>				

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K0050 SS=C	<p>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> <p>Based on review of the "Monthly Fire Drill Report" forms with the Director of Plant Operations on 11/01/11 at 2:40 p.m., all second shift fire drills took place between 6:26 p.m. and 7:48 p.m. for four of the last four quarters. This was acknowledged by the Director of Plant Operations at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p>	K0050	<p>No residents were affected by the deficient practice. All residents have the potential to be affected by the same deficient practice. A second shift fire drill was conducted at 3:30pm on 11/18/2011.1. Plant Ops Director will be inserviced on making sure to conduct quarterly fire drills at unexpected times as per regulations by Plant Ops Home office Support/Designee.2. Plant Ops Home Office Support/Designee will audit fire drill logs 1x monthly for compliance of conducting quarterly fire drills at unexpected times.3. Any non-compliance issues will be addressed immediately and staff responsible will be re-educated/disciplined as appropriate per facility disciplinary policy.Plant Ops Director/Designee will bring all audits to the QA Committee for review x 6 months, and then quarterly thereafter until 100% compliance is achieved.Date of Compliance: December 1, 2011</p>	12/01/2011	
K0130 SS=E	OTHER LSC DEFICIENCY NOT ON 2786				

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	<p>Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. 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 any resident, staff or visitor in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 11/01/11 at 12:38 p.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room. Based on interview with the Director of Plant Operations at the time of</p>	K0130	<p>No residents were affected. Any resident, staff or visitor in the main dining room has the potential to be affected by the same deficient practice. The rolling fire door in the kitchen has been inspected as per regulation. The facility has no other rolling fire doors. 1. Plant Ops Director will be inserviced on making sure to have rolling fire door in the kitchen inspected as per regulation by Plant Ops Home Support/Designee. 2. Plant Ops Support/Designee will review inspection on rolling fire door for compliance 1x monthly for first month and then quarterly thereafter. 3. Any non-compliance issues will be addressed immediately and staff responsible will be re-educated/disciplined as appropriate per facility disciplinary policy. Plant Ops Director/Designee will bring reviews of inspections on rolling door to the QA Committee for review x 1month, and then quarterly thereafter until 100% compliance is achieved. Date of Compliance: December 1, 2011</p>	12/01/2011	

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K0147 SS=E	<p>observation, he was aware the the rolling fire door required an inspection and is awaiting one.</p> <p>3.1-19(b)</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords such as an appliance extension cord was not used as a substitute for fixed wiring. 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 any resident at the northeast nurses' station.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Plant Operations on 11/01/11, an appliance extension</p>	K0147	<p>No residents were affected. Any resident at the northeast nurses station has the potential to be affected by the same deficient practice. The appliance extention cord was immediately removed. All refrigerators were checked and no other extention cords found. 1. Staff will be inserviced on importance of not using extention cords for refrigerators as per regulation by Plant Ops Home Office Support/Designee. 2. Plant Ops Director/Designee will audit 1x weekly for compliance of not using extention cords to plug in refrigerators for one month and then audit monthly thereafter. 3. Any non-compliance issues will be addressed immediately and staff responsible will be re-educated/disciplined as appropriate per facility disciplinary policy. Plant Ops Director/Designee will bring all audits to the QA Committee for review x 6 months, and then quarterly thereafter until 100%</p>	12/01/2011	

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	cord was plugged in and providing power for a small dorm type refrigerator in the Director of Food Service office. Based on an interview with the Director of Plant Operations at the time of observation, this extension cord was specifically designed for appliances.  3.1-19(b)		compliance is achieved.Date of Compliance: December 1, 2011		