

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155754	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2016
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NAME OF PROVIDER OR SUPPLIER HUBBARD HILL ESTATES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 28070 CR 24 ELKHART, IN 46517
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K 0000 Bldg. 02	<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: 05/23/16</p> <p>Facility Number: 001131 Provider Number: 155754 AIM Number: 200823940</p> <p>At this Life Safety Code survey, Hubbard Hill Estates, Inc. 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 facility located on the main level of a two story facility was determined to be of Type V (111) construction and was fully sprinklered except for the lower level elevator machine room. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire</p>	K 0000	<p>Deficiency ID: K0000 Completion Date: 6/22/2016 12:00:00 AM</p> <p>Plan of Correction Text: Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our 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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K 0025 SS=E Bldg. 02	<p>alarm system installed in all resident sleeping rooms. The facility has a capacity of 66 and had a census of 49 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 garage which was used for a maintenance shop.</p> <p>Quality Review completed on 05/26/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were maintained to provide a one half 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 26 residents in one of 3 of 7 smoke compartments.</p> <p>Findings include:</p>	K 0025	<p>Deficiency ID: K025 Completion Date: 6/22/16 12:00:00 AM Plan of Correction Text:</p> <p>Corrective Action forResidents Affected: An extensive audit of all Fire Walls and Smoke Barriers will be conducted by our Maintenance team to seal any smoke penetrations on or before 6/22/16. Other residents having the potential to be affected: 26 residents could be affected by this alleged deficient practice, however there was no</p>	06/22/2016

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	<p>Based on an observation during a tour of the facility with the Director of Building Services on 05/23/16 between 11:00 a.m. and 2:11 p.m., the following ceiling smoke barriers contained unsealed penetrations:</p> <ol style="list-style-type: none"> 1. In the ceiling of the mechanical room on the Rehab hall, there were two unsealed two inch by three inch holes. 2. In the ceiling of the janitor ' s closet on the 2300 hall, there was an unsealed fourth of an inch gap around a heating duct. 3. In the ceiling of the mechanical room on the 2300 hall, there was an unsealed fourth of an inch gap around a heating duct. 4. In the ceiling of the Health Care Activity office, there was an unsealed fourth of an inch hole around a wire. <p>Based on interview at the time of observation, the Director of Building Services acknowledged and provided the Measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in</p>		<p>actual harm to anyresidents. Measures to ensurepractice does not reoccur: By 6/10/2015 the Maintenance Department was re-educated on K0025. The maintenance supervisor or designee will inspect these areas semi-annually as part of our PreventativeMaintenance Program. Corrective Action will be monitored by: The results of this monitoring will be brought to the Safety Committee at which time any issues and corrections will be discussed.The results of this review will then be taken to the quarterly QAPI meeting. Monitoring will be on-going.</p>		

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K 0062 SS=F Bldg. 02	<p>accordance with LSC Section 8-3. LSC Section 8.3.2 requires smoke barriers to be continuous from outside wall to outside wall, from floor to floor, and through all concealed spaces, such as those found above a ceiling. This deficient practice could affect up to 18 residents in the rehab hall.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Director of Building Services on 05/23/16 at and 2:15 p.m., in the attic of the smoke barrier wall on the rehab hall there was an unsealed fourth of an inch gap between the smoke wall and roof decking. The gap ran the length of the smoke wall. Based on interview at the time of observation, the Director of Building Services acknowledged and provided the Measurements of the gap.</p> <p>3.1-19(b)</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>1. Based on record review and interview, the facility failed to ensure 1 of 1 automatic dry sprinkler piping systems</p>	K 0062	Deficiency ID: K062 Completion Date: 6/22/16 12:00:00 AM or Sooner Plan of Correction Text:	06/13/2016

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	<p>was inspected every five years as required by NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Director of Building Services on 05/23/16 at 10:35 a.m., the only internal pipe inspection available for review was completed in 2010. Based on an interview with the Director of Building Services at the time of record review and a phone call at 9:00 a.m. on 5/25/16, no other documentation was available for review to show an internal pipe inspection was completed in the last five years.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to clean and maintain 2 of 4 sprinklers in the laundry room. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient</p>		<p>Corrective Action for Residents Affected:</p> <p>1. The Internal Sprinkler Pipe Inspection, required every 5-years, was completed 6/1/16.</p> <p>2. The 4-sprinkler heads in the laundry room will be inspected weekly during daily M-F during Daily Building Checks by our Maintenance Department starting 6/13/16.</p> <p>Other residents having the potential to be affected: All residents have the potential to be affected, however there was no actual harm to any residents.</p> <p>Measures to ensure practice does not reoccur: By 6/10/16 the Maintenance team was re-educated on findings of K062. The maintenance supervisor or designee will inspect areas M-F as part of our Daily Building Checks.</p> <p>Corrective Action will be monitored by: The results of this monitoring will be brought to the Safety Committee at which time any issues will be discussed along with how they were immediately corrected. The results of this review will then be taken to the quarterly QAPI meeting. Monitoring will be on-going.</p>		

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	<p>practice was not in a resident area but can affect any staff in the laundry and service hall.</p> <p>Findings include: Based on an observation during a tour of the facility with the Director of Building Services on 05/23/16 at 11:45 a.m., the two automatic sprinklers in the laundry room above the dryers where completely covered with dust and lint. Based on interview, this was acknowledge by the Director of Building Services at the time of observation.</p> <p>3.1-19(b)</p>				