

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/27/2015
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NAME OF PROVIDER OR SUPPLIER LAKEVIEW VILLAGE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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K 0000 Bldg. 01	<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: 07/27/15</p> <p>Facility Number: 000216 Provider Number: 155323 AIM Number: 100267580</p> <p>At this Life Safety Code survey, Whispering Pines Rehabilitation Centre 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) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard wired smoke detectors in all resident rooms. The facility has a capacity of 80 and had a census of 41 at</p>	K 0000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider or any conclusion set forth in the statement of deficiencies or any violation of regulation. Provider desires that the 2567 plan of correction be considered the letter of credible compliance and requests a desk review certification in lieu of a revisit on or after 08/26/2015.</p> <p>Brenda D. Shepherd, HFA Administrator</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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K 0051 SS=F Bldg. 01	<p>the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one detached garage and the canopy which was outside the secondary exit for B hall were not sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 Based on observation and interview, the facility failed to install 1 of 1 fire alarm</p>			K 0051	K051 NFPA 101 Life Safety Code Standard		07/28/2015

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	<p>systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 07/27/15 at 2:30 p.m., with the Administrator the fire alarm system circuit breaker located in an electrical panel in the corridor wall of B hall next to the Nurse' station lacked identification and was accessible to anyone. Based on interview on 07/27/15 concurrent with review with the Administrator it was acknowledged the fire alarm circuit breaker was not properly identified and the panel box was not locked.</p> <p>3.1-19(b)</p>		<p>A fire alarm system with approved components, devices, or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patients sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests area available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station.</p> <p><i>What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient</i></p>	

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			<p><i>practice?</i></p> <p>1.) The electrical panel is now properly labeled and locked indicating "FIRE ALARM CIRCUIT CONTROL" <i>How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</i></p> <p>1.) All Residents have the potential to be affected by the deficient practice 2.) No Residents were affected by the deficient practice <i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</i></p> <p>1.) The electrical panel was properly labeled indicating "FIRE ALARM CIRCUIT CONTROL" and lock was installed on 7/28/15 by the Maintenance Supervisor 2.) Please see attached picture indicating same <i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be</i></p>		

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K 0056 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD 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		<i>put into place and</i> 1.) The Maintenance Supervisor was re-educated on the proper labeling and locking of the electrical panels for the fire alarm system by the Administrator on 7/28/15. 2.) The Maintenance Supervisor or designee will conduct monthly audits indefinitely to ensure the label and lock are in place at all times 3.) Findings of the monthly audits will be reviewed during the Quality Assurance Committee Meetings and any deficient practice will be corrected immediately <i>By what date the systemic changes will be completed</i> 7/28/2015		

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	<p>flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 4 steel armover sprinkler pipes observed was installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect all residents in the building if the sprinkler system required repair as well as staff or visitors.</p> <p>Findings include:</p> <p>Based on observation on 07/27/15 at 1:15 p.m. with the Administrator, the steel sprinkler pipe armover observed exposed and below the ceiling at the east side of the porch smoking area was measured to be thirty four inches in length and unsupported.</p> <p>Based on interview on 07/27/15 concurrent with the observation with the Administrator it was acknowledged the aforementioned steel sprinkler pipe armover exceeded twenty four inches in length and was unsupported.</p>	K 0056	<p>K056 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is a automatic sprinkler systems, 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><i>What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?</i></p> <p>1.) A sprinkler pipe holding clamp was purchased and</p>	08/26/2015

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 3 exits with outside canopies in accordance with NFPA 13, Standard for the 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 combustible roofs or canopies exceeding four feet in width. This deficient practice could affect 10 residents on B hall as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 07/27/15 at 2:01 p.m. with the Administrator, the canopy outside the secondary exit for B hall was constructed of a vinyl material for the ceiling with a support system constructed of wood was measured to extend sixty four inches from building and lacked sprinkler protection. Based on interview at the time of observation, the Administrator acknowledged the lack of sprinkler protection by the aforementioned B hall exit canopy which was over four feet in length.</p>		<p>installed on 7/28/15</p> <p>2.) A sprinkler pipe and sprinkler head was ordered on 08/01/2015 and awaiting delivery/installation from Elwood Fire and Equipment Company. Installation has been scheduled for 8/24/2015</p> <p><i>How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</i></p> <p>1.) All Residents have the potential to be affected by the deficient practice</p> <p>2.) No Residents were directly affected by the deficient practice</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</i></p> <p>1.) A sprinkler pipe holding clamp was installed on 7/28/15</p> <p>2.) See attached picture of installed clamp</p> <p>3.) A sprinkler pipe and sprinkler head was ordered on 08/01/2015 and waiting delivery/installation from the Elwood Fire and Equipment</p>	

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	3.1-19(b)		<p>Company. Installation has been scheduled for 8/24/2015</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place and</i></p> <p>1.) The Maintenance Supervisor was re-educated by the Administrator on 7/28/15 of how many feet apart the clamps should be installed and how many feet of canopy/overhang should a sprinkler head be utilized/installed</p> <p>2.) A facility wide audit was conducted by the Maintenance Supervisor on 7/28/15 and found no further over hangs that did not have sprinkler coverage</p> <p>3.) The Maintenance Supervisor or designee will complete monthly audits indefinitely to ensure no further sprinkler pipes lack any clamp device and are within the required feet apart of installation</p> <p>4.) The Maintenance Supervisor or designee will submit to the Quality</p>	

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K 0143 SS=E Bldg. 01	<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> <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 oxygen storage rooms where oxygen transfer occurs had continuously working electrically powered mechanical ventilation. This deficient practice could affect 12 residents on A hall as well as visitors and staff in the area.</p> <p>Findings include:</p>	K 0143	<p>Assurance Committee findings from the monthly audits</p> <p>5.) Any deficient practice identified will be corrected immediately</p> <p><i>By what date the systemic changes will be completed</i> 8/26/2015</p> <p>K143 NFPA 101 LIFE SAFETY CODE STANDARD Transferring of Oxygen is: (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>	07/28/2015

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	<p>Based on observation on 07/27/15 at 2:06 p.m. with the Administrator, the oxygen storage room A hall used to store and transfer oxygen was provided with a working electrically powered mechanical vent, but was not operating at the time of observation. Based on interview on 06/16/15 concurrent with the observation it was acknowledged by the Administrator this room was used to transfer oxygen and did not have a working electrically powered vent in the room.</p> <p>3.1-19(b)</p>		<p>(b.) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <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 00 and the compressed gas association. 8.6.2.5.2</p> <p>Standard for the installation of sprinkler systems</p> <p><i>What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?</i></p> <p>1.) A new mechanical vent was installed on 7/28/15 by the Maintenance Supervisor</p> <p><i>How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</i></p> <p>1.) All Residents have the potential to be affected by the deficient practice</p>	

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			<p>2.) No Residents were directly affected by the deficient practice <i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</i></p> <p>1.) Maintenance Supervisor installed a new mechanical vent in the oxygen transfer room on 7/28/15</p> <p>2.) <i>Please see attached picture indicating same How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place and</i></p> <p>1.) Maintenance Supervisor was re-educated by the Administrator on the use of a mechanical vent on 7/28/15</p> <p>2.) Maintenance Supervisor or designee will conduct weekly audits for 30 days then bi-weekly audits for 30 days then monthly thereafter indefinitely to ensure that the mechanical vent is properly working</p> <p>3.) Findings of the audits will be reviewed during</p>	

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			<p>monthly Quality Assurance Committee Meetings</p> <p>4.) Any deficient practice identified will be corrected immediately</p> <p><i>By what date the systemic changes will be completed</i> 7/28/15</p>		