

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 12/19/2012
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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, IN 46542
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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: 12/19/12</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 Recertification Survey which was conducted on December 19, 2012. 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 January 11, 2013. Considering the volume, scope, and severity of the alleged deficient practice noted in the CMS-2567, Lakeland Rehabilitation and Healthcare Center respectfully requests a desk review for this survey. If approved, we would be willing to provide all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised, or implemented as a part of this Plan of Correction.</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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	<p>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 60 and had a census of 48 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 a shed providing the storage of maintenance supplies and lawn equipment and two additional off site storage units; one unit is used for the storage of maintenance parts and supplies and the other is used for the storage of activity supplies.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/21/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 South hall unit manager's offices with combustibles measuring over 50 square feet in size was provided with a self closing device. This deficient practice could affect any of the 26 residents on the South hall.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 12/19/12 at 1:15 p.m., the corridor door to the South hall unit manager's office, measuring 180 square feet in size, lacked a self closing device. The unit manager's office contained 58</p>	K0029	No residents were affected by the deficient practice. Any of the 26 residents on the South Hall have the potential to be affected by the same deficient practice. The self closing door device was installed immediately on the South hall unit manager's office. All offices were reviewed to see if self closing door devices warranted. No other offices without a self closing door device required one at this time. 1. Executive Director/Designee will inservice Plant Ops Director on regulation K029 and the reason for the self closing door device on the South hall unit manager's office. 2. QA Action plan implemented to ensure no other office or area of facility is used to store resident records without a self closing door device. 3. Plant Ops Director/Designee has placed self closing door device on the South hall unit manager's office. Plant Ops Director/Designee will bring	01/11/2013

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	cardboard boxes of resident records and paperwork. Measurements were provided by the Director of Plant Operations at the time of observation. 3.1-19(b)		action plan to QA Committee for review x 3 months, and then quarterly thereafter until 100% compliance is achieved. Date of compliance is January 11, 2013		

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K0048 SS=D	<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 use of the K-class fire extinguisher 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 any number of kitchen staff.</p> <p>Findings include:</p> <p>Based on record review with the Director of Plant Operations on 12/19/12 at 2:25 p.m., the "Disaster Manual" did not address</p>	K0048	<p>No residents or kitchen staff were affected by deficient practice. Any number of kitchen staff could be affected by the same deficient practice. The new disaster policy had an addendum added to include the K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. Staff were inserviced on Dec 3, 2012 by Koorsen Fire and Safety regarding how to use a fire extinguisher, and the different types of extinguishers, and when to use which one including the K-class one. The inservice included a simulated fire on a screen and each staff person had to use a fire extinguisher to put out the fire. 1. Executive Director/Designee will inservice Dept Leaders regarding bringing all new policy and procedures to QA Committee for review. 2. The new disaster manual had an addendum added to include the K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. Plant Ops/Designee will bring the new disaster manual and addendum to QA Committee for review. QA Committee will review all new policy and procedures for next 6 months and then quarterly thereafter until QA</p>	01/11/2013

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	<p>the kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. Based on an interview with the Director of Plant Operations at the time of record review, this was a new copy of the Disaster Manual.</p> <p>3.1-19(b)</p>		Committee states otherwise. Date of Compliance is January 11, 2013		

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K0062 SS=D	<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 restrooms in resident room 109. 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 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 of 16 residents in the East hall.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 12/19/12 at 12:45 p.m., there was a buildup of paint on the sprinkler head in the restroom of resident room 109 on the East hall. The Director of Plant</p>	K0062	<p>No residents were affected. 2 of 16 residents in the East hall have the potential to be affected by the same deficient practice. The sprinkler head in the bathroom of room 109 will be replaced. The Plant Ops Director checked the sprinkler heads in all resident bathrooms for compliance. 1. Executive Director/Designee will inservice Plant Ops Director on regulation K062 and review reason sprinkler head in bathroom of room 109 needed to be replaced. 2. Plant Ops has set up for Korsen fire and safety to come out and replace sprinkler head in bathroom 109. 3. Plant Ops Director/Designee will audit sprinkler heads for compliance 1x monthly until QA states otherwise. Any sprinkler head with paint, corrosion, damage, etc. will be replaced. Plant Ops Director/Designee will bring all audits to QA Committee for review x 3 months and then quarterly thereafter until 100% compliance is acheived. Date of Compliance is January 11, 2013</p>	01/11/2013			

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	<p>Operations acknowledged there was paint on the sprinkler head in the restroom of resident room 109 at the time of observation.</p> <p>3.1-19(b)</p>			

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K0154 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to protect 48 of 48 residents by providing a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and</p>	K0154	<p>No residents were affected. All residents have the potential to be affected by the same deficient practice. The new Emergency Fire Watch policy was updated to include the designated person(s) shall have no other duties or responsibilities while conducting the fire watch.1. Executive Director/Designee will inservice Dept Leaders regarding bringing all new policy and procedures to QA Committee for review.2. The new Emergency Fire Watch policy was updated to include the designated person(s) shall have no other duties or responsibilities while conducting the fire watch.3. Plant Ops Director/Designee will inservice staff on new updated Emergency Fire Watch policy.Plant Ops/Designee will bring the new updated Emergency Fire Watch policy to QA Committee for review. QA Committee will review all new policy and procedures for next 6 months and then quarterly thereafter until QA Committee states otherwise.Date of Compliance is January 11,</p>	01/11/2013			

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	<p>11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned and lastly 11-7 requires notification of everyone again when the system is restored. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Emergency Fire Watch" policy with the Director of Plant Operations on 12/19/12 at 2:20 p.m., the facility did have a written policy and procedure for an impaired sprinkler system available for review, but it did not include the designated person(s) shall have not other duties or responsibilities while conducting the fire watch. Based on an interview with the Director of Plant Operations at the time of record review, he acknowledged the fire watch policy lacked documentation stating the person(s) conducting the fire watch shall be assigned no</p>		2013				

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	other duties. 3.1-19(b)			

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K0155 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 48 of 48 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3</p>	K0155	<p>No residents were affected. All residents have the potential to be affected by the same deficient practice. The new Emergency Fire Watch policy was updated to include the designated person(s) shall have no other duties or responsibilities while conducting the fire watch. 1. Executive Director/Designee will inservice Dept Leaders regarding bringing all new policy and procedures to QA Committee for review. 2. The new Emergency Fire Watch policy was updated to include the designated person(s) shall have no other duties or responsibilities while conducting the fire watch. 3. Plant Ops Director/Designee will inservice staff on new updated Emergency Fire Watch policy. Plant Ops/Designee will bring the new updated Emergency Fire Watch policy to QA Committee for review. QA Committee will review all new policy and procedures for next 6 months and then quarterly thereafter until QA Committee states otherwise. Date of Compliance is January 11, 2013</p>	01/11/2013

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	<p>requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Emergency Fire Watch" policy with the Director of Plant Operations on 12/19/12 at 2:20 p.m., the facility did have a written policy and procedure for an impaired fire alarm system available for review, but it did not include the designated person(s) shall have not other duties or responsibilities while conducting the fire watch. Based on an interview with the Director of Plant Operations at the time of record review, he acknowledged the fire watch policy lacked documentation stating the person(s) conducting the fire watch shall be assigned no other duties.</p> <p>3.1-19(b)</p>				

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