

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 06/26/2015
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 02	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 04/28/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/26/15</p> <p>Facility Number: 001131 Provider Number: 155754 AIM Number: 200823940</p> <p>At this PSR survey, Hubbard Hill Estates, Inc. was found in substantial 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</p>	K 0000	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.	

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=B Bldg. 02	<p>open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 66 and had a census of 58 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>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 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 the penetrations caused by the passage of wire and/or conduit through the smoke barrier wall in 3 of 4 resident room halls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3</p>	K 0025	<p>Corrective Action for Residents Affected:</p> <p>Corridor smoke barriers were installed on halls 2200, 2300 and 2400. Additionally, all barrier</p>	07/02/2015

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	<p>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 residents in the 2200, 2300, 2400 halls and near the nurses' station.</p> <p>Findings include:</p> <p>Based on observation and interview on 06/26/15 from 11:49 a.m. to 1:50 p.m., the Director of Building Services and Building Services Personnel #1 acknowledged the following unsealed penetrations above the ceiling tile:</p> <p>a) at the 2400 hall smoke barrier wall there were three penetrations measuring in size from one half inch around IT cables to one eight inch around plumbing lines</p> <p>b) at the 2300 hall smoke barrier wall there were five penetrations measuring from two by three inches wide to one fourth inch around IT cables</p> <p>c) at the 2200 hall smoke barrier wall there was a penetration measuring one</p>		<p>penetrations were sealed with fire caulk. This work was completed on 7/2/15 as stated on the attached Statement of Completion by DJ Construction.</p> <p>Other residents having the potential to be affected: No other residents were found to be affected by this alleged deficient practice.</p> <p>Measures to ensure practice does not reoccur: On 5/15/2015 the Maintenance Department was re-educated on K044 in regards to maintaining the integrity of the smoke barriers by insuring that all barrier penetrations are sealed with fire caulk. No work is to be done in the attic without notification of the Maintenance Supervisor or his designee. The Maintenance Supervisor or his designee will inspect</p>				

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	inch by six inches around water lines with five additionally penetrations measuring from one fourth inch to three fourths inch 3.1-19(b)		these areas semi-annually as part of our Preventative Maintenance Program. Corrective Action will be monitored by: Results of our Preventative Maintenance Program will be brought to the Safety Committee bi-monthly meeting 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.		