

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2014
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NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
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K010000	<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: 07/23/14</p> <p>Facility Number: 000108 Provider Number: 155653 AIM Number: 100267410</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist.</p> <p>At this Life Safety Code Survey, Lake County Nursing and Rehabilitation 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 two story facility determined to be of Type II (222) construction was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and in areas opened to the</p>	K010000	<p>August 16, 2014 Kim Rhoades, Director of Long Term Care Indiana State Department of Public Health 2 North Meridian St. Sec 4-B Indianapolis, In 46204-3006 Dear Ms.Rhoades: Please reference the enclosed 2567 as "Plan of Correction" for the July 23, 2014 Life Safety code Survey Recertification that was conducted at Lake County Nursing and Rehabilitation Center. I will submit signature sheets of the in-servicing, content of in-service and audit tools August 16, 2014. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community. The Plan of Correction submitted on August 16, 2014 serves as our allegation of compliance. Should you have any question or concerns regarding the Plan of Corrections, please contact me.</p> <p>Respectfully, Neysa</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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	<p>identified. This deficient practice affects all visitors, staff and residents in on the first and second floors.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/23/14 between 12:30 p.m. and 4:45 p.m., east and west exits serving sleeping rooms on the first and second floors discharged onto a patio with two gates in a six foot chain link fence. The one gate in each fence opened onto a grassy lawn and one discharged to a sidewalk leading to the public way. The gates were identical and the actual emergency exits were not marked with signs. The maintenance director acknowledged the exit was not clearly marked.</p> <p>3.1-19(b)</p>		<p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice:</p> <p>"Based on observation and interview, the facility failed to ensure 2 of 4 exits means of egress from the first and second floor sleeping room wings were clearly identified."</p> <p>No visitors, staff or residents residing in the facility were identified as being adversely affected.</p> <p>The facility labeled the</p>		

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			<p>appropriate path of egress gates located from the first and second floor sleeping room wings with an Actual Emergency Exit sign.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>All visitors, staff and residents residing in the facility have the potential to be affected. Any concerns will be addressed immediately.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>The Maintenance Director completed a visual audit of all exit means of egress and determine all other exit means of egress were clearly identified.</p>		

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K010025 SS=E	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 Based on observation and interview, the	K010025	4. To ensure the deficient practice does not reoccur, the monitoring system established is to: Maintenance Director / Designee will audit twice monthly to ensure exit means of egress are clearly identified. The audit will be presented and reviewed monthly for the next 3 months at the Quality Assurance meeting. QA committee will determine if continued auditing is necessary. 5. Completion date systemic changes will be completed: 8/22/14	08/22/2014

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	<p>facility failed to ensure smoke partition openings such as walls and ceilings in 3 of 6 smoke compartments were sealed to limit the transfer of smoke. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke. This deficient practice could affect visitors, staff and and 20 or more residents in the west second floor and east first floor smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/23/14 between 12:30 p.m. and 4:30 p.m.:</p> <p>a. A 24 by 24 inch ceiling tile was missing from the lay in ceiling of the electrical closet of the second floor resident dining room to expose insulation and gaps into the interstitial spaces above;</p> <p>b. An eight by twelve inch cutout in the ceiling around pipes penetrating the ceiling of the "old linen room" across from room 206 was unsealed with additional damage to the ceiling where sections were broken away and open into the space above the ceiling;</p> <p>c. A ceiling duct penetration and two, three inch holes in the wall of the furnace room near room 106 were unsealed leaving 1/2</p>		<p>K025</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: No residents, staff or visitors were identified as being adversely affected.</p> <p>a. A 24 by 24 inch ceiling tile was missing from the lay in ceiling of the electrical closet of the second floor resident dining room to expose insulation and gaps into the interstitial spaces above.</p>	

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	<p>and 3/4 inch gaps into the interstitial spaces behind the wall and ceiling;</p> <p>d. A three inch pipe penetrating the ceiling of the oxygen supply room had a gap of two inches around it;</p> <p>e. An eight inch pipe penetrating the soiled laundry room ceiling was unsealed leaving a two inch gap around its circumference;</p> <p>f. A ceiling tile was missing from the lay in ceiling of the MDS office. The maintenance director said at the time of observations, he hadn't known the penetrations were unsealed.</p> <p>3.1-19(b)</p>		<p>b. An eight by twelve inch cutout in the ceiling around pipes penetrating the ceiling of the "old linen room" across from 206 was unsealed with additional damage to the ceiling where sections were broken away and open into the space above the ceiling.</p> <p>c. A ceiling duct penetration two, three inch holes in the wall of the furnace room near room 106 were unsealed leave 1/2 and 3/4 inch gaps into the interstitial spaces behind the wall and ceiling.</p> <p>d. A three inch pipe penetrating the ceiling of the oxygen supply room had a gap of two inches around it.</p> <p>e. An eight inch pipe penetrating the soiled laundry room ceiling was unsealed leaving a two inch gap around its circumference.</p> <p>f. A ceiling tile was missing from the lay in ceiling of the MDS office.</p> <p>a. The Maintenance Department replaced the missing ceiling tile in the electrical closet</p>	

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			<p>of the second floor resident dining room.</p> <p>b. The Maintenance Department installed drywall and applied fire rated caulking at the pipes penetrating the ceiling of the "old linen room" across from 206. The damaged ceiling tile was replaced.</p> <p>c. The two, three inch holes in the wall of the furnace room near 106 were sealed with drywall and fire rated caulking to eliminate penetration of smoke barrier.</p> <p>d. The Maintenance Department repaired the two inch gap around the three inch pipe penetrating the ceiling of the oxygen room by installing drywall and applying fire rated caulking.</p> <p>e. The Maintenance Department repaired the two inch gap around the eight inch pipe that was penetrating the soiled laundry room ceiling by installing drywall and applying fire rated caulking.</p> <p>f. The Maintenance Department replaced the ceiling tile in the MDS office.</p>	

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			<p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>All visitors, staff, and residents residing in the facility have the potential to be affected. Any concerns will be addressed immediately.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>The Administrator or designee will complete Environmental Audit twice weekly to ensure that facility is in compliance.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>Maintenance Director / Designee will monitor facility and complete Environmental Audit tool twice weekly. Any issues found will be addressed immediately. The audits will be discussed during</p>	

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K010029 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 provide automatic closers for doors providing access to 2 of 10 hazardous areas such as a combustible materials storage room larger than 50 square feet and a hazardous waste collection room. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close</p>	K010029	<p>monthly QA meeting for the next 3 months. QA committee will determine if continued auditing is necessary once compliance threshold is achieved. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 8/22/14</p> <p>K029</p> <p>PLAN OF CORRECTION</p>	08/22/2014

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	<p>automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 30 or more residents on the second floor and any staff in the service corridor for which resident access is restricted.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 07/23/14 at 1:00 p.m., the door separating room 223, a former resident room larger than 50 square feet used for storing combustible mattresses, cardboard cartons and wood furniture not in use, had no self closer. The maintenance director said at the time of observations, he didn't know doors to rooms larger than 50 square feet storing combustibles were required to self close.</p> <p>b. Based on observation with the maintenance director on 07/23/14 at 2:25 p.m., the south door separating the second floor soiled utility room used for the collection of hazardous waste did not self close. Upon closer inspection at the time of observation, the maintenance man said the self closer was missing screws required for it to operate.</p> <p>c. Based on observation with the maintenance director on 07/23/14 at 3:10 p.m., the door separating the eight by ten foot storage room from the service corridor had no self closer.</p>		<p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: No residents, staff or visitors were identified as being adversely affected.</p> <p>"Based on observation and interview, the facility failed to provide automatic closer for doors providing access to 2 of 10 hazardous area."</p> <p>a. Based on observation, the door separating room 223, a former resident room larger than 50 square feet used for storing combustible mattresses, cardboard cartons and wood furniture not in use had no self-closer.</p> <p>b. The south door separating the second floor soiled utility room used for the collection of hazardous waste did not self-close.</p> <p>c. The door separating the eight by ten foot storage room</p>	

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	3.1-19(b)		<p>from the service corridor had no self-closer.</p> <p>a. The facility installed an automatic door closer on the door separating room 223, a former resident room larger than 50 square feet used for storing combustible mattresses, cardboard cartons, and wood furniture.</p> <p>b. The facility installed an automatic door closer on the south door separating the second floor soiled utility room used for the collection of hazardous waste</p> <p>c. The facility installed an automatic door closer on the door separating the eight by ten foot storage room from the service corridor.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>All visitors, staff, and residents residing in the facility have the potential to be affected. Any concerns will be addressed immediately.</p>	

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			<p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>The Maintenance Director or designee will conduct an audit monthly of the 10 facility doors with automatic closers to ensure proper function. Any door requiring additional equipment will be repaired in a timely manner. The Maintenance Department was educated on the importance of ensuring that all appropriate doors are equipped with automatic closer.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>Maintenance Director or Designee will audit <u>10</u> facility doors with automatic closer monthly to ensure that each automatic closer is in proper condition and to install any closer</p>	

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 7 emergency exits would open fully. LSC 7.2.1.4 requires any door in a means of egress shall be installed so it is capable of swinging from any position to the full required width of the opening in which it is installed. Additionally, 7.1.10.1 requires a means of egress shall be continuously maintained free of all obstructions or impediments to full and</p>	K010038	<p>to ensure regulation is met. The audits will be presented and reviewed for the next 3 months during our monthly QA meeting. QA committee will determine if continued auditing is necessary once compliance threshold is achieved. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 8/22/14</p> <p>K038</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction.</p>	08/22/2014

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	<p>instant use in case of fire or other emergency. This deficient practice affects all visitors, staff and residents on the first and second floor sleeping room wings.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/23/14 between 12:30 p.m. and 4:45 p.m., each exit discharge path for the east and west exits required passage through a six foot chain link fence to reach the public way. A latch would open the gate. It was difficult to open, so the maintenance director demonstrated his ability to open the latch and the gate. Nurse # 1 was asked on 07/23/14 at 2:45 p.m. to demonstrate opening the gate. She was unable to do so. She said as she made repeated attempts, she was unfamiliar with how the latch worked and had not been trained to open the gate. The maintenance director acknowledged at the time of demonstration, staff had not been inserviced to operate the gate latch making it inaccessible for evacuation purposes.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 4 exterior</p>		<p>This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: No residents, staff or visitors were adversely affected.</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 7 exits would open fully. The east and west passage through a six foot chain link fence to reach the public way was difficult to open.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 4 exit doors was arranged to automatically close and latch. The exit door providing access to the west exit discharge was open and remained open. The self-closer was found to have had the screws which allowed the door to self-close were removed.</p> <p>1. The Maintenance Department replaced the latch on</p>	

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	<p>exit doors was arranged to automatically close and latch. LSC 19.2.1 requires every exit discharge, location and access shall be in accordance with Chapter 7. LSC 7.2.1.8.1 says a door normally required to be kept closed shall not be secured in the open position at any time and shall be self closing or automatic closing. This deficient practice affects visitors, staff and 10 or more residents of the west first and second floor sleeping room wings.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/23/14 at 3:40 p.m., the exit door providing access to the west exit discharge was opened and remained open. Upon closer inspection, the self closer was found to have had the screws which allowed the door to self close, removed. The maintenance director said at the time of observation, the screws were found to have been removed at least monthly.</p> <p>3.1-19(b)</p>		<p>the east and west passage gates to ensure easy access for exiting.</p> <p>2. The missing screws were replaced on the west exit door.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>All staff, visitors, residents residing in the facility have the potential to be affected. Any concerns will be addressed immediately.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>On 7/25/14 the Maintenance Director in-serviced staff on how to operate the new gate latch and re-educated staff on the use of maintenance repair form.</p> <p>Any issues identified will be addressed immediately.</p> <p>4. To ensure the deficient</p>	

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K010051 SS=F	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		<p>practice does not reoccur, the monitoring system established is to:</p> <p>Maintenance Director / Designee will audit the east and west passage gates latch and the West exit door self- closure twice monthly to ensure proper function. Any issues found will be addressed immediately. The audits will be discussed for the next 3 months during our monthly QA meeting. QA committee will determine if continued auditing is necessary once compliance threshold is achieved. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 8/22/14</p>	

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	<p>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</p> <p>Based on interview and record review, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 3-8.1 allows fire alarm system components to share control equipment or operate as stand alone systems, but in any case, they shall be arranged to function as a single system. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/23/14 at 2:05 p.m., the manual pull station on the west wing of the second floor was used to demonstrate the initiation of the fire alarm signal. There was no alarm although the smoke barrier doors released from the magnets holding them open, and</p>	K010051	<p>K051</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: No visitors, staff or residents residing in the facility were adversely affected.</p>	08/22/2014			

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	<p>closed. The same resulted upon activation of the east wing manual pull station on the second floor and the fire alarm pull station in the lobby of the first floor. There was no audible alarm at the fire alarm control panel (FACP) and the LED screen noted a trouble for "second phone line" there was nothing to indicate there was trouble with the horns/strobes. The maintenance director rechecked that all pull stations were reset and tried again with the same result. He called the fire alarm system contractor who directed him to do a "hard reset" which meant he disconnected the FACP battery and shut the FACP switch off. The only LED trouble note was for the secondary phone line. This trouble was on "silence", removed, and the pull stations were tested on the second floor with an audible alarm sounding. The alarm was silenced and the first floor fire alarm pull station was pulled the audible alarm did not sound in the building. The maintenance director said during the testing, he understood that an alarm should have sounded again when the first floor pull station was activated prior to resetting the pull station on the second floor after the alarm had been silenced.</p> <p>3.1-19(b)</p>		<p>"Based on the interview and record review, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 3-8 allows fire alarm system components to share control of equipment or operate as stand-alone systems, but in any case, they shall be arranged to function as a single system."</p> <p>Online Communications and Koorsen Fire Alarm System are scheduled to make repairs to the Fire Alarm System running new NAC wire and splitting the (1) NAC circuit into (2) in order to properly power the circuit and ensure the Fire Alarm system is functioning properly.</p> <p>The fire alarm secondary line was repaired by Online Communication on 7/25 /14</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>This deficient practice could affect all residents, staff, and visitors. No residents, staff or visitors were identified as being adversely affected.</p>	

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			<p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>The facility is consulting with an outside contractor to ensure that system is in proper working condition consistently during testing of the fire alarm system and that all appropriate signals are indicated on a Quarterly basis.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>Maintenance Director / Designee will test fire alarm system twice monthly for 3 months to ensure that system is in proper working condition consistently during testing. Any issues found will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once compliance threshold is achieved. This plan to be</p>		

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K010062 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 ensure 1 of 1 environmental services supply room sprinkler heads was free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice could affect two or more visitors and staff in the environmental services supply room.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K010062	<p>amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 8/22/14</p> <p>K062</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken</p>	08/22/2014

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	<p>maintenance director on 07/23/14 at 3:10 p.m., the wall partition separating paint storage from the environmental supply storage room terminated eight inches from the ceiling of the room. A single sprinkler head on the environmental services supply side was installed to protect all spaces within the room. The maintenance director acknowledged at the time of observation, the wall terminated less than the minimum distance allowed between a sprinkler head and obstruction.</p> <p>3.1-19(b)</p>		<p>for the resident found to have been affected by the deficient practice: No residents, staff or visitors were adversely affected.</p> <p>1. Based on observation and interview, the wall partition separating paint storage from the environmental supply storage room terminated eight inches from the ceiling of the room. A sprinkler head on the environmental services supply side was installed to protect all spaces within the room.</p> <p>1. The Maintenance Director lowered the wall partition separating the paint storage and the environmental supply storage room to ensure it was at the minimum distance allowed between the sprinkler head and obstruction.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>All staff, visitors, and residents residing in the facility have the potential to be affected. Any concerns will be addressed immediately.</p>		

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			<p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>The Administrator re- in-serviced the Maintenance and Maintenance Assistance on the minimum distance allowed between the sprinkler head and obstruction on 7/25/14. An audit was conducted on 7/25/14 of sprinkler heads in the facility to ensure allowable distance between the sprinkler head and obstruction. No issues were identified.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>Maintenance Director / Designee will audit 5 sprinklers weekly for 3 months to ensure allowable distance between the sprinkler head and obstruction. Any issues found will be addressed immediately. The audits will be</p>		

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K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gases in resident rooms and 3 of 19 oxygen e-cylinders stored in the oxygen supply storage room were properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires</p>	K010076	<p>discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once compliance threshold is achieved. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 8/22/14</p> <p>K076</p> <p>PLAN OF CORRECTION</p>	08/22/2014

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	<p>cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect visitors, staff and 10 or more residents in the east second floor smoke compartment and anyone in the service corridor for which access to residents is restricted.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/23/14 between 12:30 p.m. and 4:45 p.m., one oxygen e-cylinder was stored without support in resident room 214 and three oxygen e-cylinders were free standing in the oxygen supply storage room. The maintenance director acknowledged at the time of observations, the cylinders should not have been left unsupported.</p> <p>3.1-19(b)</p>		<p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: No visitors, staff or residents residing in the facility were adversely affected.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gases in resident rooms and 3 of 19 oxygen e-cylinders stored in the oxygen supply storage room were properly stored.</p> <p>1. The Maintenance Director remove 1 of 1 cylinder of nonflammable gas from resident room 214.</p> <p>2. The 3 of 19 oxygen e-cylinders that were free standing were relocated to an oxygen cart located in the oxygen</p>	

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			<p>supply storage room where they are properly secured with cylinder stand.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>All staff, visitors, residents residing in the facility have the potential to be affected. Any concerns will be addressed immediately.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>The Maintenance Department and staff was in-serviced on proper storage of oxygen tanks and free standing e-cylinders. All new or incoming tanks are to be properly secured in a stand or cart.</p> <p>4. To ensure the deficient practice does not reoccur, the</p>	

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K010144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation, interview and record review; the facility failed to ensure the off site fuel source for 1 of 1	K010144	monitoring system established is to: All oxygen cylinders and free standing e-cylinders were properly stored. The Maintenance Department was in-serviced on proper storage to ensure compliance is met. The Maintenance Department Director will report any concerns relating to Oxygen directly to the Administrator and concerns will be immediately with reports brought to monthly Quality Assurance meeting. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 8/22/14	08/22/2014	

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	<p>emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <p>a) Liquid petroleum products at atmospheric pressure</p> <p>b) Liquefied petroleum gas (liquid or vapor withdrawal)</p> <p>c) Natural or synthetic gas</p> <p>Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source.</p> <p>CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:</p> <ol style="list-style-type: none"> 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the 		<p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: No visitors, staff or residents residing in the facility were adversely affected.</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA99.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the off-site fuel source for 1 of 1 emergency generators was from a reliable source.</p>	

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	<p>statement regarding the reliability.</p> <p>3. A statement that there is a low probability of interruption of the natural gas.</p> <p>4. A brief description that supports the statement regarding the low probability of interruption,</p> <p>5. The signature of a technical person from the natural gas provider.</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/23/14 at 3:55 p.m., the emergency generator was fueled with natural gas. The maintenance director confirmed at the time of observation, there was no liquid fuel back up. Based on record review with the maintenance director on 07/23/14 at 4:15 p.m., a letter from the facility's natural gas provider was not found in the generator documentation. The maintenance director said at the time of record review there was a letter but he could not find it. He immediately consulted with the executive director who was unable to provide the document.</p> <p>3.1-19(b)</p>		<p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>All staff, visitors, and residents residing in the facility have the potential to be affected.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>The Administrator contacted NIPSCO (local gas provider) requesting a statement of reasonable reliability of the natural gas delivery, a brief description that supports the statement regarding the reliability and a statement that the there is low probability of interruption of the natural gas. The Administrator received the Reasonable Reliability letter from the natural gas source/ provider on 8/11/14. The Reasonable Reliability letter from the natural gas source/ provider will be located in the Maintenance Binder and facility Contract Binder located in the Administrator's office.</p>	

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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
			<p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>The Maintenance Director was In-serviced on the importance of providing appropriate documentation to ensure that the facility's gas provider for the facility generator provides proof annually with a statement of reasonable reliability of the natural gas delivery and a brief description that supports the statement regarding the reliability and that there is low probability of interruption of the natural gas. The Maintenance Department was also educated that the description must include a description that supports the statement regarding the low probability of interruption and must contain a signature of a technical person from the natural gas provider. The Administrator or designee will discuss any concerns related to this matter with the Quality Assurance Committee monthly.</p> <p>5. Completion date systemic changes will be completed: 8/22/14</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2014
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K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure 4 of 4 flexible cords were not used as a substitute for fixed wiring. NFPA 70 National Electrical Code, 1999 Edition, 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 staff, visitors and 20 or more residents in the west smoke compartment of the first floor and the east smoke compartment of the second floor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/23/14 between 12:30 p.m. and 5:00 p.m., power strip extension cords were located:</p> <p>a. Adjacent to the resident bed to power resident equipment in room 224;</p> <p>b. At the head of the resident bed in room 213;</p> <p>c. Under the head of the bed in resident room 211;</p>	K010147	<p>K147</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice:</p> <p>1. Based on observation, the facility failed to ensure 4 of 4 flexible cords were not used as a</p>	08/22/2014

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	<p>d. In the employee break room to power a microwave and refrigerator. The maintenance director said at the time of observations, he did not know the power strips were being used.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain electrical outlets in 2 of 7 areas open to the exit corridor. NFPA 101, 19.5.1 requires utilities to comply with Section 9.1. NFPA 101, 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 1999 edition, Article 410.3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects visitors, staff and 10 or more residents in the west smoke compartments on the first and second floors.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/23/14 at 2:20 p.m., an electrical receptacle in the employee break room and in the resident lounge were each cracked with a section of the faceplates broken off to expose the</p>		<p>substitute for wiring. Power strip extension cords were located:</p> <p>a. Adjacent to the resident bed to power resident equipment in room 224.</p> <p>b. At the head of the resident bed in room 213.</p> <p>c. Under the head of the bed in resident room 211.</p> <p>d. In the employee break room to power microwave and refrigerator.</p> <p>2. The facility failed to maintain electrical outlets in 2 of 7 areas open to the exit corridor. An outlet in employee break room and in the resident lounge area were cracked with a section of the faceplates broken.</p> <p>1. a. The Maintenance Director removed the power strip in room 224.</p> <p>b. The Maintenance Director removed the power strip in room 213.</p> <p>c. The Maintenance Director removed the power strip in room 211.</p> <p>d. The Maintenance Director</p>	

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	<p>electric components. The maintenance director said at the time of the observations, he was unaware the receptacles were broken.</p> <p>3.1-19(b)</p>		<p>removed the power strip in the employee break room and provided appropriate electrical receptacle.</p> <p>2. The Maintenance Department repaired the faceplates on the outlets in the resident lounge area and the employee break room.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>All staff, visitors, and residents residing in the facility have the potential to be affected by the alleged deficient practice. Any concerns will be addressed immediately.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>The Maintenance Director conducted a facility wide audit to ensure that all outlets are in working condition and no further</p>	

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			<p>extension cord or power strip equipment is being used. The Maintenance Director was in-serviced that any extension cord or power strip is not a substitution for electrical wiring.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>Maintenance Director / Designee will audit 5 rooms weekly for 3 months to ensure flexible cords are not used as a substitute for wiring, electrical power strips are used properly / not used at the head of the resident's bed and electrical outlet faceplates are not damaged. Any issues found will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once compliance threshold is achieved. This plan to be amended when indicated.</p>	

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