

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155352	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2015
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NAME OF PROVIDER OR SUPPLIER ELKHART REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 MOREHOUSE AVE ELKHART, IN 46517
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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: 05/22/15</p> <p>Facility Number: 000243 Provider Number: 155352 AIM Number: 100289830</p> <p>At this Life Safety Code survey, Elkhart 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 one story facility was determined to be of Type III (200) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. Battery operated smoke detectors are provided in the resident sleeping rooms. The facility has a capacity of 58 with a census of 41 at the</p>	K 0000	Preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth or facts alleged or conclusion set forth in this Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. Elkhart Rehabilitation Center desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective June 21, 2015.	

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 0014 SS=F Bldg. 01	<p>time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except the garage, a shed, and the smoke tent.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure materials used as an interior finish in the corridor had a flame spread rating of Class A, Class B or Class C in order to protect 41 of 41 residents. LSC 101 10.2.3.2 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development.</p> <p>(a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not</p>	K 0014	<p>K014</p> <p>The wood board ceilings in resident rooms, lobby, therapy office, hallway and kitchen are being reviewed by an architectural engineer to determine what the project needs to meet the 2000 Edition of the NFPA Life Safety Code. Any new products entering the facility will be reviewed/inspected by the Maintenance Director for flame spread information. The Maintenance Director will ensure that all new products meet flame spread requirements. Proper documentation of the flame spread of a product is to be obtained prior to the installation of the product by the Maintenance Director. The Maintenance Director will ensure that all flame spread documentation is retained. All existing and future flame spread</p>	06/21/2015

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	<p>continue to propagate fire.</p> <p>(b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale.</p> <p>(c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect all residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility on 05/22/15 from 11:40 a.m. to 1:35 p.m., there were wood boards on the ceiling in all resident rooms, the main lobby, the therapy office and the kitchen. Interview with the Maintenance Supervisor after the time of observations revealed no documentation was immediately available to demonstrate the wood boards exhibited a flame spread classification of Class A, B or C.</p> <p>3.1-19(b)</p>		<p>documentation will be reviewed by the Administrator with the Maintenance Director on an annual basis to ensure all documentation is available.</p> <p>Completion Date: We request a two week extension for K014 to enable an outside vendor to determine the best course of action (7/5/15). At that time we will submit our final plan and move forward with the approved plan.</p>	

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K 0018 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure the door protecting corridor opening in 1 of 1 business office was smoke resistive. This deficient practice could affect any resident near the business office.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 05/22/15 at 12:40 p.m., the corridor doors entering the business office were Dutch doors. There was a one half inch by four inch gap between the doors on the door hinge side. The Maintenance Supervisor confirmed the measurements at the time of observation.</p>	K 0018	<p>K018 The Dutch door leading into the business office will be replaced with a door that is substantial such as those constructed of 1 ¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Completion Date: 6/21/15</p>	06/21/2015			

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K 0025 SS=F Bldg. 01	<p>3.1-19(b)</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>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3 of 3 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 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 all occupants.</p>	K 0025	<p>K025</p> <p>The expandable foam and yellow putty type substance has been replaced with the appropriate Fire Barrier Sealant in all three penetrations in the smoke barrier walls.</p> <p>a) The two unsealed ceiling penetrations measuring one half inch and two inches in the Medical Records Office was sealed with appropriate Fire Barrier Sealant 5/31/15.</p> <p>b) The unsealed penetration in the corridor wall near the ceiling measuring two inches by six inches around cable lines and another unsealed penetration measuring one inch by four inches around a bundle of Internet and phone lines in the Medical Supply Room was sealed 5/31/15 with appropriate Fire Barrier Sealant.</p> <p>An audit of the entire facility to</p>	06/21/2015
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	<p>Findings include:</p> <p>Based on observations with Maintenance Supervisor on 05/22/15 from 3:20 p.m. to 3:35 p.m., the penetrations in all three smoke barrier walls were sealed with either expandable foam or a yellow putty type substance. Based on an interview with the Maintenance Supervisor at the time of observation, he was not aware the expandable foam was not an approved sealant for smoke barrier walls and he was unable to provide documentation to confirm the yellow putty was a material capable of maintaining the smoke resistance rating of the smoke barrier wall.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 1 of 2 corridor walls 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 was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>a) Based on an observation with the</p>		<p>determine any additional penetrations in smoke barrier walls will be completed by the Maintenance Director and reviewed by the Administrator by 6/15/15. Any additional identified smoke barrier wall penetrations will be sealed with appropriate Fire Barrier Sealant.</p> <p>Once a month for 12 months the Maintenance Director will perform an audit of the entire facility to determine if any new penetrations in smoke barrier walls have occurred. The Maintenance Director/designee is to keep a log documenting date and time of his audit and any identified concerns. Identified concerns are to be addressed immediately to ensure compliance.</p> <p>The Administrator is to review the smoke barrier audit monthly for 12 mos. Administrator is to round once a quarter with the Maintenance Director during a smoke barrier audit once a quarter for 12 mos.</p> <p>The Maintenance Director/designee will report during the monthly QA meeting compliance, identified trends and concerns, and how trends and concerns have been addressed.</p> <p>The QA Committee members are to make recommendations as needed.</p> <p>Completion Date: June 21, 2015.</p>	

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K 0029 SS=E Bldg. 01	<p>Maintenance Supervisor on 05/22/15 at 12:46 p.m. there were two unsealed ceiling penetrations measuring one half inch and two inches in the medical records office. The Maintenance Supervisor acknowledged the ceiling penetrations at the time of observation.</p> <p>b) Based on an observation with the Maintenance Supervisor on 05/22/15 at 12:15 p.m., there was an unsealed penetration in the corridor wall near the ceiling measuring two inches by six inches around cable lines and another unsealed penetration measuring one inch by four inches around a bundle of Internet and phone lines in the medical supply room. At the time of observation, the Maintenance Supervisor acknowledged and confirmed the measurements.</p> <p>3.1-19(b)</p> <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</p>						

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	<p>permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 2 of 2 hazardous areas, such as the kitchen and the laundry room, were self closing and latch into the door frame. This deficient practice could affect 30 residents in the main dining room and any residents near the laundry room.</p> <p>Findings include:</p> <p>Based on an observation on 05/22/15 at 12:56 p.m., the Maintenance Supervisor acknowledged the corridor door entering the kitchen failed to latch into the door frame. At 1:08 p.m., the Maintenance Supervisor acknowledged one of two corridor doors entering the laundry room failed to latch into the door frame.</p> <p>3.1-19(b)</p>	K 0029	<p>K029</p> <p>The corridor door entering the kitchen was adjusted 06/02/15, is self-closing and latches into the door frame.</p> <p>The corridor door entering the laundry room was adjusted 06/02/15, is self-closing and latches into the door frame.</p> <p>An audit of all corridor doors in the facility is to be completed by 06/15/15. All corridor doors are to be self-closing and latch into the door frame. Any necessary corrections are to be made by June 21, 2015.</p> <p>The Maintenance Director and the Administrator are to be in-serviced on inspecting doors during routine rounds to ensure all corridor doors are self-closing and are able to latch into their frames.</p> <p>The Maintenance Director/designee is to complete corridor door inspections during daily (Monday – Friday) rounds. The Maintenance Director/designee is to keep a log documenting date and time of his rounds and any identified concerns. Identified concerns are to be addressed immediately to ensure compliance.</p> <p>The Maintenance Director/designee is to present a “Rounding Log” to</p>	06/21/2015	

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K 0038 SS=E Bldg. 01	<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>Based on observation and interview, the facility failed to ensure 1 of 3 exit access corridors was readily accessible and unobstructed at all times. This deficient practice could affect any of the 18 residents on south hall.</p> <p>Findings include:</p>	K 0038	<p>the Administrator/designee once a day (Monday – Friday) for two weeks, then once a week for one month, then monthly thereafter.</p> <p>The Administrator/designee will review “Rounding log” once a day (Monday – Friday) for two weeks, then once a week for one month, then monthly thereafter to monitor compliance, identify trends, ensure concerns are addressed and compliance is maintained.</p> <p>Maintenance Director/designee will report during the monthly QA meeting compliance, identified trends and concerns, and how trends and concerns have been addressed.</p> <p>The QA Committee members are to make recommendations as needed.</p> <p>Completion Date: June 21, 2015.</p> <p>K038 The set of wooden steps in the corridor outside of the therapy gym have been permanently removed from the hallway. Therapy staff will be notified, and signatures obtained indicating they received the notification, that the set of wooden steps cannot be in</p>	06/21/2015

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	<p>Based on an observation with the Maintenance Supervisor on 05/22/15 at 12:00 p.m., there was a set of wooden steps in the corridor outside the therapy gym. Based on an interview with the Maintenance Supervisor at the time of observation, the steps are used in the corridor and at night they are moved into the therapy gym.</p> <p>3.1-19(b)</p>		<p>the hallway. Completion date 6/9/15.</p> <p>The Maintenance Director/designee is to complete daily (Monday – Friday) rounds to ensure exit access is accessible at all times. The Maintenance Director/designee is to keep a log documenting date and time of his rounds and any identified concerns. Identified concerns are to be addressed immediately to ensure compliance.</p> <p>The Maintenance Director/designee is to present a “Rounding Log” to the Administrator/designee once a day (Monday – Friday) for two weeks, then once a week for one month, then monthly thereafter.</p> <p>The Administrator/designee will review “Rounding log” once a day (Monday – Friday) for two weeks, then once a week for one month, then monthly thereafter to monitor compliance, identify trends, ensure concerns are addressed and compliance is maintained.</p> <p>Maintenance Director/designee will report during the monthly QA meeting compliance, identified trends and concerns, and how trends and concerns have been addressed.</p> <p>The QA Committee members are to make recommendations as needed.</p> <p>Completion Date: June 21, 2015.</p>		

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K 0045 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to ensure the failure of any single fixture or bulb would not leave the area in darkness at 1 of 6 emergency exits. This deficient practice could affect any of the 23 residents in the north hall.</p> <p>Finding include:</p> <p>Based on observation and interview on 05/22/15 at 12:48 p.m., the Maintenance Supervisor acknowledged the exterior exit discharge from the north hall was equipped with a single light fixture with a single bulb.</p> <p>3.1-19(b)</p>	K 0045	<p>K045</p> <p>The North Hall exterior light fixture will be replaced with a dual bulb light fixture to ensure illumination of the area.</p> <p>The Maintenance Director/designee is to complete daily (Monday – Friday) rounds to ensure illumination of means of exit discharge. The Maintenance Director/designee is to keep a log documenting date and time of his rounds and any identified concerns. Identified concerns are to be addressed immediately to ensure compliance.</p> <p>The Maintenance Director/designee is to present a “Rounding Log” to the Administrator/designee once a day (Monday – Friday) for two weeks, then once a week for one month, then monthly thereafter.</p> <p>The Administrator/designee will review “Rounding log” once a day (Monday – Friday) for two weeks, then once a week for one month, then monthly thereafter to monitor compliance, identify trends, ensure</p>	06/21/2015

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K 0048 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>Based on record review and interview, the facility failed to provide a written plan that included the evacuation of a smoke compartment 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 	K 0048	<p>concerns are addressed and compliance is maintained.</p> <p>Maintenance Director/designee will report during the monthly QA meeting compliance, identified trends and concerns, and how trends and concerns have been addressed.</p> <p>The QA Committee members are to make recommendations as needed.</p> <p>Completion Date: 06/21/15</p> <p>K048 Administrator has shown the Maintenance Director the Evacuation Policy and Procedure and where it is located in the Emergency Preparedness Plan binder. The Administrator will insure all Emergency Preparedness Plan binders in the facility contain the Evacuation Policy and Procedure. All staff will be in-serviced on the Evacuation Policy and Procedure and where it is located in the Emergency Preparedness Plan binder. Completion date: 6/21/15</p>	06/21/2015

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K 0052 SS=E Bldg. 01	<p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a record review with Maintenance Supervisor on 05/22/15 at 11:30 a.m., the "Fire Safety Plan" did not address the evacuation of a smoke compartment. Based on an interview at the time of review, the Maintenance Supervisor acknowledged the documentation for the aforementioned issue was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure 4 of 23 smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests</p>	K 0052	<p>K052</p> <p>The Maintenance Director will contact VanGuard Alarm Services by 6/9/15.</p> <p>VanGuard Alarm Services is to perform an audit of all smoke detectors in the facility by performing a Sensitivity Test. All smoke detectors not meeting listed and marked sensitivity range will be replaced.</p> <p>The Maintenance Director is to</p>	06/21/2015

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	<p>indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could</p>		<p>report to the Administrator the results of the Sensitivity Test and the actions he has taken to replace smoke detectors that do not pass the Sensitivity Test.</p> <p>The Maintenance Director will be responsible for making sure sensitivity tests are completed in a timely manner once per quarter for four quarters.</p> <p>The Maintenance Director will report to the Administrator 1 time per quarter for four quarters the results of smoke detector Sensitivity Tests. The Maintenance Director is to report any detectors that do not pass the sensitivity test. The Administrator is responsible to verify with the Maintenance Director that smoke detectors that do not pass the sensitivity test are replaced 1 time per quarter for four quarters.</p> <p>Completion Date: 6/21/15</p>	

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K 0056 SS=E Bldg. 01	<p>affect any number of occupants in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor on 05/22/15 at 11:45 a.m. the 08/21/13 Vanguard smoke detector record titled "Sensitivity Test" indicated four smoke detectors had failed the sensitivity test. Based on an interview at the time of record review, the Maintenance Supervisor stated the smoke detectors had not been repaired or replaced.</p> <p>3.1-19(b)</p> <p>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 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 1 nurses'</p>	K 0056	<p>K056</p> <p>1. The deflector sprinkler head in the nurse's station will be</p>	06/21/2015			

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	<p>station sprinkler heads was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 5-5.4.2 states deflectors of sprinklers shall be aligned parallel to ceilings, roofs, or the incline of stairs. This deficient practice could affect any occupant in the vicinity of the nurses' station.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 05/22/15 at 12:05 p.m., the deflector for the side wall sprinkler head in the nurses's station was installed on the wall with the deflector at an angle to the ceiling. The Maintenance Supervisor acknowledged at the time of observation, this sprinkler head was not installed in the correct orientation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure only one type of sprinkler head i.e. quick response or standard sprinklers were installed in 1 of 1 medical record office. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a smoke compartment</p>		<p>reinstalled by SafeCare to the correct orientation 6/9/15.</p> <p>2. One quick response sprinkler head will be replaced with a standard response sprinkler head in the Medical Records Office by SafeCare 6/9/15 to ensure all four sprinkler heads in the Medical Records Office are of the same type. The Maintenance Director will perform an audit of all sprinkler heads in the facility to ensure all sprinkler heads have the correct orientation and that all sprinkler heads in individual smoke compartments are of the same type. The audit is to be completed by 6/8/15. Sprinkler heads with an incorrect orientation will be reinstalled by SafeCare 6/9/15. Smoke compartments with more than one type of sprinkler head will have the necessary sprinkler heads replaced by SafeCare 6/9/15, in order that all sprinkler heads in a smoke compartment are of the same type.</p> <p>The Maintenance Director will provide the Administrator documentation of his sprinkler head audit and documentation of all corrections/installations made by SafeCare by 6/10/15.</p> <p>The Maintenance Director will report his audit results and corrections to the QA committee during the next QA meeting.</p> <p>Completion Date: 6/21/15</p>	

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K 0062 SS=F Bldg. 01	<p>shall be changed. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 05/22/15 at 12:46 p.m., there was one quick response sprinkler head and three standard response sprinkler heads mounted on the ceiling in the medical records office. The Maintenance Supervisor acknowledged there was one quick response sprinkler head with a thin glass rod and three standard response sprinkler heads with a thicker glass rod mounted on the ceiling in the medical records office.</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 observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was provide with a complete supply of spare sprinklers in accordance with NFPA 25, 1998 Edition 2-4.1.4 which requires a supply of at least six spare sprinklers</p>	K 0062	<p>K062</p> <p>1. Two green liquid filled glass rod sprinkler heads will be obtained from SafeCare 6/9/15.</p> <p>The Maintenance Director will audit the sprinkler heads to document the types of sprinklers installed in the facility by 6/8/15. Any sprinkler type without the proper number of</p>	06/21/2015

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	<p>shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 05/22/15 at 12:51 p.m., there were green liquid filled glass rod sprinkler heads mounted on the ceiling in the walk in cooler, freezer and in the dry food storage area. Based on an interview with the Maintenance Supervisor at the time of observation, there were no green liquid filled glass rod sprinkler heads in the spare sprinkler cabinet.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 fire hydrants was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998</p>		<p>spares will be noted and spare sprinklers will be obtained from SafeCare 6/9/15.</p> <p>The Maintenance Director will verify that the adequate number of spare sprinklers for each type of sprinkler in the facility is available.</p> <p>At least six spare sprinklers will be in stock with a minimum of two spare sprinklers per sprinkler type installed in the facility will be maintained at all times by the Maintenance Director.</p> <p>The Maintenance Director will report to the Administrator whenever a spare sprinkler is used and provide documentation that a new spare is immediately obtained. The Maintenance Director will verify and document the number of spare sprinklers monthly for 12 months and report his documentation monthly to the QA committee.</p> <p>2. All yellow fire hydrants are located in the Right of Way and are owned by the City of Elkhart. The City of Elkhart services these hydrants. This was verified by the Elkhart Department of Public Works and Utilities Department. The Siamese Intake Valve on the front side of the facility is to be inspected quarterly during the quarterly sprinkler system inspection.</p> <p>SafeCare is scheduled to inspect the Siamese Intake Value 6/9/15. The Maintenance Director will be held responsible to make sure the</p>	

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K 0064 SS=D Bldg. 01	<p>Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected and the necessary corrective action shall be taken. This deficient practice could affect all staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation and interview with the Maintenance Supervisor on 05/22/15 at 11:55 a.m., he was unable to confirm if the fire hydrant in front of the property was maintained by the city. He stated in the year he has been with the facility neither the facility nor the city had inspected the fire hydrant.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ABC kitchen fire extinguisher was readily accessible at all times. NFPA 10, Standard for Portable Fire Extinguishers, Section 1-6.3 requires that fire</p>	K 0064	<p>Siamese Intake is inspected during the quarterly sprinkler system inspections and to keep documentation that the inspection has occurred. The Administrator will verify with the Maintenance Director that this has occurred 1 time per quarter for four quarters. Completion Date: 06/21/15</p> <p>K064 The portable cart and trash can were relocated 5/28/15 to ensure the kitchen ABC fire extinguisher is not obstructed from view. All dietary staff are to be in-serviced on keeping the area in front of and</p>	06/21/2015			

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	<p>extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 05/22/15 at 12:55 p.m., access to the kitchen ABC fire extinguisher was obstructed from view by a portable cart and a large trash can. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>around the extinguisher free of objects.</p> <p>The Dietary Manager is to ensure the area remains free of objects by inspecting daily (Monday – Friday). The Dietary Manger is to keep a log documenting date and time of inspection and any identified concerns. Identified concerns are to be addressed immediately to ensure compliance. Dietary Staff who are not compliant in keeping the area clear will be re-education one time. Any non-compliance thereafter will result in disciplinary action up to and including termination of employment.</p> <p>The Dietary Manager is to present an "Inspection Log" to the Administrator/designee once a day (Monday – Friday) for two weeks, then once a week for one month, then monthly for 3 months, then quarterly thereafter up to one year.</p> <p>The Administrator/designee will inspect the area once a day (Monday – Friday) for two weeks, then once a week for one month, then monthly for 3 months, then quarterly thereafter up to one year to monitor compliance, identify trends, ensure concerns are addressed and compliance is maintained.</p> <p>Dietary Manager will report during the monthly QA meeting compliance, identified trends and</p>				

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K 0066 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 areas where smoking was permitted for staff and residents were maintained. This deficient practice could affect 20 residents in the resident smoking area and facility staff.</p>	K 0066	<p>K066 The Maintenance Director removed all cigarette butts and lint in the designated staff smoking area and the laundry exit door 5/28/15. The cigarette butts and paper trash in the metal trash can were removed 5/28/15. The cigarette butts in the</p>	06/21/2015	

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	<p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 05/22/15 at 1:40 p.m., there were cigarette butts on the ground commingled with lint from the dryers in the designated staff smoking area and at least 50 cigarette butts on the ground near the laundry exit door. Additionally, there were cigarette butts and paper trash in the metal trash can. At 12:55 p.m., at least 30 cigarette butts were observed on the ground in the resident smoking area. This was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p>		<p>resident smoking area were removed 6/1/15.</p> <p>It was determined that there were holes in the dryer lint screen which contributed to the amount of lint outside the building. A new dryer lint screen was installed 6/8/15.</p> <p>The Maintenance Director/designee is to complete daily (Monday – Friday) rounds. Any cigarette butts, lint outside the building, trash in the metal trash can is to be removed daily (Monday – Friday). The Maintenance Director/designee is to keep a log documenting date and time of his rounds and any identified concerns. Identified concerns are to be addressed immediately to ensure compliance.</p> <p>The Maintenance Director/designee is to present a “Rounding Log” to the Administrator/designee once a day (Monday – Friday) for two weeks, then once a week for one month, then monthly thereafter.</p> <p>The Administrator/designee will review “Rounding log” once a day (Monday – Friday) for two weeks, then once a week for one month, then monthly thereafter to monitor compliance, identify trends, ensure concerns are addressed and compliance is maintained.</p> <p>Maintenance Director/designee will report during the monthly QA meeting compliance, identified trends and concerns, and how</p>		

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K 0069 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on record review and interview on 05/22/15 at 11:40 a.m., the Maintenance Supervisor acknowledged he was unable to provide documentation of a hood extinguishing system inspection prior to 02/17/15.</p> <p>3.1-19(b)</p>	K 0069	<p>trends and concerns have been addressed.</p> <p>The QA Committee members are to make recommendations as needed.</p> <p>Completion Date: June 21, 2015.</p> <p>K069 The Maintenance Director found a copy of a hood extinguishing system inspection dated 08/05/14. The Maintenance Director determined a belt needed replaced. The belt was replaced 6/2/15. The Maintenance Director is to schedule VanGuard to inspect the hood extinguishing system. The Maintenance Director is to ensure the hood extinguishing system is inspected according to manufacture instructions and performed by qualified service personnel a minimum of once every 6 months or more frequently if required, and all documentation is readily available for review. The Maintenance Director is to ensure all problems identified by the hood inspection are to be corrected within a reasonable amount of time. The Administrator is to review with the Maintenance Director hood inspections immediately upon the completion of the inspection.</p>	06/21/2015

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K 0147 SS=E Bldg. 01	<p>2. Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was maintained in proper working order. NFPA 96, 10-6.5 requires inspection and testing of the total operation and all safety interlocks in accordance with the manufacturer's instructions shall be performed by qualified service personnel a minimum of once every 6 months or more frequently if required. This deficient practice was not in a resident area but could affect kitchen staff.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor on 05/22/15 at 9:50 a.m., the 02/17/15 Vanguard fire hood inspection report noted "exhaust fan not working not pulling enough air through the hood". Based on an interview with the Maintenance Supervisor at the time of observation, the facility was not aware nor have they addressed this problem.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the</p>	K 0147	The Maintenance Director is to report inspection findings and actions to ensure compliance during the QA meeting. Completion Date: 6/21/15	06/21/2015	

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	<p>facility failed to ensure 6 of 9 flexible cords and 3 of 3 multiplug adapters were not used as a substitute for fixed wiring to provide power for high current equipment. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, 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 any number of residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 05/22/15 during a tour from 11:42 a.m. to 12:45 p.m., the following was noted:</p> <p>a) there was an extension cord power strip providing power to an extension cord, a multiplug adapter in use and a power strip providing power to a window mounted AC unit in the Director of Nursing's office</p> <p>b) there was a multiplug adapter powering a router and refrigerator, an extension cord power strip plugged into another extension cord power strip and an extension cord providing power to an extension cord power strip in the medication room</p> <p>c) a refrigerator was plugged in and provided with power from an extension</p>		<p>Center's intent for flexible cords and cables to not be used as a substitute for fixed wiring to provide power for high current equipment. a) The extension cord power strip providing power to an extension cord, a multi-plug adapter and a power strip providing power to a window mounted AC unit in the Director of Nursing's office has been removed. 6/1/15 b) The multi-plug adapter powering a router and refrigerator, an extension cord power strip plugged into another extension cord power strip and an extension cord providing power to an extension cord power strip in the medication room has all been replaced. 6/1/15 c) The refrigerator in the medical records room is now plugged directly in the wall outlet. 6/1/15 d) The multi-plug adapter was replaced in the Activities Room. 6/1/15 e) The extension cord providing power to an extension cord power strip in the medical supply room has been removed. 6/1/15 The Administrator with the Maintenance Director is to do an audit of the entire facility to ensure compliance by 6/11/15. Any identified issues are to be communicated to the Maintenance Director for correction. The Maintenance Director is to do weekly rounds of the entire facility to ensure compliance once a week for 3 months, then monthly thereafter</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155352	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2015
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NAME OF PROVIDER OR SUPPLIER ELKHART REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 MOREHOUSE AVE ELKHART, IN 46517
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K 0154 SS=C Bldg. 01	<p>cord power strip in the medical records room</p> <p>d) a multiplug adapter was providing power to electronic equipment in the activity room</p> <p>e) there was an extension cord providing power to an extension cord power strip in the medical supply room</p> <p>3.1-19(b)</p> <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 provide a 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. in order to protect 34 of 34 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire</p>	K 0154	<p>for one year. The Maintenance Director is to keep a log of his rounds documenting date of the rounds and identified non-compliance and correction of non-compliance. The Administrator is to review once a month for 12 months. The Maintenance Director is to report the findings of his rounds at the QA meeting to the QA Committee. Completion Date: 06/21/15</p> <p>K154 The Administrator is to review policy and will ensure a written policy is in place containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service. All staff will be educated on the policy and instructed on procedures concerning patrolling the facility in the event the sprinkler system is out of service. Education will include patrol, documentation, ready access to fire extinguishers, promptly notifying the fire department, and clear path of egress routes.</p>	06/21/2015

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NAME OF PROVIDER OR SUPPLIER ELKHART REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 MOREHOUSE AVE ELKHART, IN 46517		
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	<p>department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. NFPA 25, A-11-5(c)2 states, "a fire watch should consist of trained personnel who continuously patrol the effected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly." This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview on 05/22/15 at 10:35 a.m., the Maintenance Supervisor acknowledged the facility failed to provided for a plan of action when the automatic sprinkler system was out of service for more than four hours in a twenty four hour period.</p> <p>3.1-19(b)</p>		<p>The Administrator will ensure copies of the written policy is available in all Emergency Preparedness Plan binders.</p> <p>Staff will be in-serviced on the policy once a quarter for four quarters.</p> <p>Completion Date: 6/21/15</p>		