

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 04/02/2014
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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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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: 04/02/14</p> <p>Facility Number: 000243 Provider Number: 155352 AIM Number: 100289830</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</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</p>	K010000		
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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>sleeping rooms. The facility has a capacity of 58 with a census of 51 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except the garage, a shed, and the smoke tent.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/10/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010018 SS=E	<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 3 of 50 corridor doors closed and latched into the door frame. This deficient practice could affect at least 10 residents through out the facility as well as an undetermined number of staff.</p> <p>Findings include:</p> <p>Based on observation with the Administrator on 04/02/14 from 12:30 p.m. to 2:15 p.m., the following was noted:</p> <p>a. The soiled laundry room door lacked a functioning latching device. b. The clean linen/laundry room door hit the frame and did not latch. c. The therapy room door latch was not</p>	K010018	<p>K 18 Three doors were noted in facility as not properly latching. The soiled laundry room, employee lounge and folding room doors will all latch correctly by 5/2/14. All facility employees have been educated to ensure all doors in facility latch correctly. All employees will be educated on proper documentation for obtaining maintenance to repair latches. All doors which open to the hallway corridors will be checked weekly by Maintenance/designee. Maintenance will report in safety committee meeting and follow in QPI any ongoing issues monthly with doors and latches.</p>	05/02/2014			

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	<p>functioning. Based on interview at the time of observation, the Administrator acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p>			

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K010029 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 doors serving hazardous areas such as a kitchen closed and latched to prevent the passage of smoke. This deficient practice could affect all residents using the dining room as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Administrator during a tour of the facility on 04/02/14 from 12:30 p.m. to 2:15 p.m., the kitchen door to the dining room lacked a door closer.</p> <p>Based on interview at the time of observation, the Administrator acknowledged the kitchen door to the dining room did not self close and latch to prevent the passage of smoke.</p> <p>3.1-19(b)</p>	K010029	K 29 Door between main dining room and kitchen lacking a door closer. Dietary staff will be educated how to complete maintenance repair slips concerning door latches and closures. Closure will be installed by 5/2/14 on door between main dining room and kitchen. Kitchen staff will monitor door closure and latching with each meal and complete work order in not working correctly. QPI will monitor latching and closing of all hallway doors monthly.	05/02/2014			

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K010046 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review, observation and interview; the facility failed to ensure 4 of 4 battery operated emergency lights in the facility were maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors throughout the facility.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Emergency Lighting" documentation during record review from 10:15 a.m. to 12:30 p.m. on 04/02/14 and observation from 12:30 p.m. to 2:15 p.m., with the Maintenance Supervisor, the following was noted:</p>	K010046	K 46 Emergency lighting #2 in Kitchen was not functionaln on facility tour. Dietary will monitor emergency lighting in kitchen daily. Dietary staff will be educated on proper documentation for maintenance repair of emergency lights. Maintenance will monitor all other emergency lights five times a week for a month and then document per TELS. Follow-up monthly with QPI to monitor emergency lighting.	05/02/2014			

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	<p>a. One of the kitchen battery operated emergency lights, EL # 2, was not functional when tested. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned battery operated emergency light did not function when tested.</p> <p>b. The documentation for the annual testing of the battery operated emergency lights in the facility was indicated as done on time in the electronic preventative maintenance system on September 4th, 2013, but none of the fields such as location or pass/fail were filled out. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the annual battery operated emergency light documentation was completed by a former Maintenance Supervisor and did not document the annual 90 minute test.</p> <p>3.1-19(b)</p>						

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K010048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review, observation and interview; the facility failed to develop a written fire safety plan to address staff response to the activation of battery operated smoke detectors installed in 31 of 31 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the Emergency Preparedness Manual documentation with the Maintenance Supervisor during record review on 04/02/14 from 10:15 a.m. to 12:30 p.m., the facility's written fire safety plan did not include staff</p>	K010048	<p>K 48 Facility policy did not reflect battery operated smoke alarms in resident rooms. Facility policy will be revised to incorporate battery operated smoke detectors. Facility will follow it policy of RACE. All facility employees will be educated on policy for resident room smoke alarms with are battery operated. Safety committee and QPI will monitor monthly with fire drills. Policy will be in compliance by 5/2/14.</p>	05/02/2014
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	<p>response to the activation of battery operated smoke detectors installed in each resident sleeping room. Based on observation with the Maintenance Supervisor and the Administrator during a tour of the facility from 12:30 p.m. to 2:15 p.m., battery operated smoke detectors were installed in each resident sleeping room. Based on interview during record review, the Maintenance Director acknowledged the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms.</p> <p>3.1-19(a)</p>			
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K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>1. Based on interview and record review, the facility failed to conduct quarterly fire drills on each shift for 1 of 4 quarters. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Reports" with the Maintenance Supervisor from 10:15 a.m. to 12:30 p.m. on 04/02/14, a fire drill was not documented for the third shift of the fourth quarter of 2013. Based on interview at the time of record review, the Maintenance Supervisor acknowledged a fire drill for the third shift of the fourth quarter of 2013 was not documented and there was no other documentation available for review to verify a drill during this time period was conducted.</p>	K010050	<p>K 50 Facility was unable to located fire drill for fourth quarter night shift. Facility unable to substantiate 13 of 15 drills included the verification of transmission of a fire alarm signal and simulation or emergency conditions. Documentation could not be provided to verify transmission of signal to fire department. Maintenance staff educated on how to properly conduct and document fire drills for facility. All fire drills will be monitored through QPI for proper documentation monthly. Maintenance will utilize TELS for documentation of fire signal.</p>	05/02/2014			

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	<p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to ensure 13 of 15 fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters included the verification of transmission of the fire alarm signal to the monitoring station. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports on 04/02/14 at 10:30 a.m. with the Maintenance Supervisor, the documentation for 13 drills performed between the hours of 6:00 a.m. and 9:00 p.m. for the past twelve months lacked verification of the transmission of the signal. In the "Communications" section of the Fire Drill Report, the question, "Was alarm received by fire department, police, or by monitoring company" was marked "No." Based on interview at the time of record review, the Maintenance Supervisor acknowledged the transmission of the fire alarm signal to</p>						

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	<p>the monitoring station was not documented for the aforementioned fire drills.</p> <p>3.1-19(b) 3.1-51(c)</p>			

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K010062 SS=F	<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 record review and interview, the facility failed to ensure 1 of 1 sprinkler system's components was inspected quarterly for 5 of 5 calendar quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on sprinkler system record review with the Maintenance Supervisor on 04/02/14 from 10:15 a.m. to 12:30 p.m., the last documented sprinkler system inspection occurred on 10/10/2012.</p>	K010062	K 62 Facility unable to provide documentation of sprinkler system inspection. Safe care provided immediate response to sprinkler inspection which was completed on 4/2/14. Gauges were found to need replaced and were replaced on 4/3/14. Noted in middle section of building in attic cable wires running along sprinkler line. Maintenance staff educated on policy for sprinkler inspections. Maintenance staff will monitor using TELS system. QPI will monitor quarterly sprinkler maintenance. Sprinkler lines in attic will have all wires and such removed from pipes by 5/2/14.	05/02/2014			

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	<p>Based on interview at the time of record review, the Maintenance Supervisor acknowledged there was no written documentation or other evidence the sprinkler system had been inspected since the fourth quarter of 2012.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor from 12:30 p.m. to 2:15 p.m. on 04/02/14, the sprinkler system located in the sprinkler riser room had two pressure gauges with a date indicating the gauges were replaced or recalibrated in 12/2008. Based on interview at the time of observation, the</p>						

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	<p>Maintenance Supervisor acknowledged the gauges were dated 12/2008.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 requires sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor from 12:30 p.m. to 2:15 p.m. on 04/02/14, a section of a four inch sprinkler pipe in the attic of the middle hall corridor had a bundle of data cables attached to it. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the sprinkler pipe was supporting a bundle of data cables.</p> <p>3.1-19(b)</p>						

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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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K010072 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of impediments to full instant use in the case of fire or other emergency for 1 of 4 exits. This deficient practice could affect at least 20 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Administrator on 04/02/14 from 12:30 p.m. to 2:15 p.m., there was a bedside dresser, four trash bins, and one soiled linen cart in the five foot wide corridor leading to the rear exit. Based on interview at the time of observation, the Maintenance Supervisor and Administrator acknowledged the means of egress was not continuously maintained free of impediments to the rear exit.</p> <p>3.1-19(b)</p>	K010072	K 72 Service hallway will be kept free of items. This service hallway measures approximately 5 feet wide. All facility staff will be educated on egress of hallways in the facility, focusing on service hallway. Items will not be stored in service hallway. Nursing will monitor for egress at least every shift. Compliance will be met by 5/2/14.	05/02/2014			

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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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K010144 SS=F	<p>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.</p> <p>1. Based on record review and interview, the facility failed to exercise the generator for 6 of 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This</p>	K010144	<p>K 144 Facility was unable to provide all monthly generator load testing documentation and weekly inspection of starting batteries for generator. Maintenance staff has been educated on generator testing expectations. TELS will be used for documentation of generator testing. Administrator will review with maintenance staff weekly inspection of batteries for generator. Monitored and reviewed monthly by QPI.</p>	05/02/2014
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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>deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of emergency generator monthly load testing documentation with the Maintenance Supervisor during record review on 04/02/14 from 10:15 a.m. to 12:30 p.m., monthly generator load tests were not documented for May, June, July, August, October and November of 2013. Based on interview at the time of record review, the Maintenance Supervisor acknowledged documentation for monthly load testing for the aforementioned months of 2013 was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections of the starting batteries for the generator was maintained for 22 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon</p>			
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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>discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview and review of generator documentation with the Maintenance Supervisor during record review on 04/02/14 from 10:15 a.m. to 12:30 p.m., weekly generator inspections were not documented for May, June, July, August, October and November of 2013.</p> <p>3.1-19(b)</p>				

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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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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>Based on observation and interview, the facility failed to ensure medical equipment and high current draw electrical devices were not plugged into power strips or nonfused multiplug adapters as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 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 at least 10 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and Administrator from 12:30 p.m. to 2:15 p.m. during a tour of the facility on 04/02/14, the following was noted:</p> <p>a. A window air conditioner was plugged into a power strip and a microwave was plugged into an extension cord in the employee break room.</p> <p>b. A refrigerator was plugged into a</p>	K010147	K 147 Facility using power strips for high current draw devices(refridgerators). All staff will be educated on high draw devices and where high draw devices should be plugged in facility. Resident rooms will not use power strips for high draw devices. QPI and Safety committee will monitor monthly for compliance. Facility will be compliant by 5/2/14.	05/02/2014			

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	<p>power strip in resident room # 34.</p> <p>c. A resident bed air mattress, two televisions and two cable adapters were plugged into a nonfused multiplug adapter in resident room # 34.</p> <p>d. A television was plugged into a power strip which was plugged into a nonfused multiplug adapter in resident room # 28.</p> <p>e. A television and cable adapter were plugged into a nonfused multiplug adapter in resident room # 25.</p> <p>f. An oxygen concentrator and television were plugged into a nonfused multiplug adapter in resident room # 17.</p> <p>Based on interview at the times of observation, the Maintenance Supervisor and Administrator acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p>				

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K010211 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>Based on observation and interview, the facility failed to ensure alcohol based hand rub dispensers were not installed over an ignition source in 14 of 31 resident rooms. This deficient practice could affect at least 30 residents and staff throughout the facility.</p> <p>Findings include:</p> <p>Based on observation on 04/02/14 with the Maintenance Supervisor and Administrator during the tour from 12:30 p.m. to 2:15 p.m., resident rooms 10, 11, 14, 17, 18, 23, 34, 27, 29, 30, 31, 32, 33 and 34 had a one liter container of 70 % alcohol based hand sanitizer mounted just inside the room within six inches of an electrical outlet and/or a light switch.</p>	K010211	K 211 Facility with alcohol based hand sanitizer mounted within six inches of electrical outlet. Maintenance staff educated on proper location for hand sanitizers. All hand sanitizer will be located at least six inches from an electrical outlet by 5/2/14.	05/02/2014			

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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>Based on an interview with the Maintenance Supervisor and Administrator, it was acknowledged the alcohol based hand sanitizer dispensers were mounted too close to an ignition source.</p> <p>3.1-19(b)</p>			