

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155269	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EAST LAKE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 JEANWOOD DR ELKHART, IN 46514
---	--

(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
--------------------	--	---------------	---	----------------------

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: 09/15/14</p> <p>Facility Number: 000169 Provider Number: 155269 AIM Number: 100267100</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, East Lake Nursing 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 V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated detectors in all</p>	K010000	<p>9/25/14 – To Whom It May Concern:</p> <p>On September 15, 2014 a Life Safety Code Survey was conducted at East Lake Nursing &amp; Rehabilitation. Attached is the plan of correction. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit. Thank you for your time and consideration,</p> <p>Martin Lebbin Executive Director East Lake Nursing and Rehabilitation</p>	
---------	--	---------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155269	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EAST LAKE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 JEANWOOD DR ELKHART, IN 46514
---	--

(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
K010051 SS=F	<p>resident sleeping rooms. The facility has a capacity of 152 and had a census of 129 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except for the detached shed which provided facility storage and was not sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/17/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>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 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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155269		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/15/2014	
NAME OF PROVIDER OR SUPPLIER  EAST LAKE NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1900 JEANWOOD DR ELKHART, IN 46514			
(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>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 observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 09/15/14 at 12:56 p.m. with the Maintenance Supervisor, the fire alarm system circuit breaker located in the electrical room on Main hall lacked full identification. Inside the panel next to breaker 15 were the letters "FA" spelled out with a black magic marker which had noticeably faded over time. Based on interview on 09/15/14 at 12:57 p.m. with the Maintenance Supervisor, it was acknowledged the circuit breaker was not labeled with red marking to say Fire Alarm Circuit Control.</p> <p>3.1-19(b)</p>	K010051	<p><b>K051 – NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this provider to make sure all fire alarm circuit breakers are properly marked in "red" identifying the "FIRE ALARM CIRCUIT CONTROL".</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>The Maintenance Supervisor clearly marked the fire alarm circuit breaker in "red" identifying the "FIRE ALARM CIRCUIT CONTROL".</p> <p>Residents did not experience any negative outcomes related to the deficient concern.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All residents have the potential to be affected by this finding. The Maintenance Supervisor clearly marked the fire alarm circuit breaker in "red" identifying the "FIRE ALARM CIRCUIT CONTROL".</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>The fire alarm circuit breaker will be checked quarterly, by the Executive Director /Maintenance Supervisor to</p>	09/19/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155269	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/15/2014
NAME OF PROVIDER OR SUPPLIER  EAST LAKE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 JEANWOOD DR ELKHART, IN 46514		
(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	
K010066 SS=E	<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</p>		<p>identify that the fire alarm circuit breaker is properly marked/identified.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b></p> <p>To ensure ongoing compliance with this corrective action, the Executive Director/Maintenance Supervisor will be responsible for checking the fire alarm circuit breaker to make sure it is properly identified. The audit of the fire alarm circuit breaker will be kept in the Fire Drill Binder. The audits will be recorded on the "Fire Drill Log". If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Safety Committee for review and follow up.</p> <p><b>By what date the systemic chances will be completed:</b> Compliance date: 9/19/14</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155269	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EAST LAKE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 JEANWOOD DR ELKHART, IN 46514
---	--

(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>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 Based on observation, record review and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container provided for 1 of 1 areas where smoking was permitted. This deficient practice could affect 24 residents on 100 hall adjacent to the outside smoking tent as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 09/15/14 at 1:15 p.m. with the Maintenance Supervisor, twenty one extinguished cigarette butts were observed deposited in a plastic container with paper debris where smoking is permitted outside the 100 hall in the smoking tent. Based on review of the smoking policy on 09/15/14 at 2:32 p.m. with the Maintenance Supervisor, the smoking policy did address the proper disposal of extinguished cigarette butts into a metal container. Based on interview on 09/15/14 at 1:17 p.m. with the Maintenance Supervisor it was</p>	K010066	<p><b>K066 – NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this provider to ensure cigarette butts are deposited into a noncombustible container in the area where smoking is permitted.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>The Maintenance Supervisor properly disposed of the cigarette butts and provided a noncombustible container in the smoking area specifically for the deposal of cigarette butts. Residents who smoke will be informed by the Executive Director/Maintenance Director about the proper way to extinguish cigarette butts. Staff that smoke will be in-serviced by the Clinical Education Coordinator/Maintenance Director about the proper way to extinguish cigarette butts. Residents did not experience any negative outcomes related to the deficient concern.</p>	10/08/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155269	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EAST LAKE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 JEANWOOD DR ELKHART, IN 46514
---	--

(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>acknowledged the facility's employees allowed the disposal of cigarette butts into a plastic container which is also used for the disposal of paper good.</p> <p>3.1-19(b)</p>		<p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All residents have the potential to be affected by this finding. The Maintenance Supervisor provided a noncombustible container in the smoking area specifically for the deposit of cigarette butts. A sign was placed on the trash container identifying it to be used only for trash and not for the disposal of cigarette butts.</p> <p>Residents who smoke will be informed by the Executive Director/Maintenance Director about the proper way to extinguish cigarette butts.</p> <p>Staff that smoke will be in-serviced by the Clinical Education Coordinator/Maintenance Director about the proper way to extinguish cigarette butts.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>The noncombustible smoking container will be checked, by Maintenance Supervisor/Designee and emptied as needed. At the same time the trash container will be checked and emptied as needed.</p> <p>Residents who smoke will be informed by the Executive Director/Maintenance Director about the proper way to extinguish cigarette butts.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155269	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EAST LAKE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 JEANWOOD DR ELKHART, IN 46514
---	--

(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>Staff that smoke will be in-serviced by the Clinical Education Coordinator/Maintenance Director about the proper way to extinguish cigarette butts.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b></p> <p>To ensure ongoing compliance with this corrective action, the Maintenance Supervisor/designee will be responsible for completion of the "Smoking Area" audit tool daily for 2 weeks, weekly for 2 weeks, bi-weekly for 2 weeks and monthly for six months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Safety Committee for review and follow up.</p> <p><b>By what date the systemic chances will be completed:</b> Compliance date: 10/08/14</p>	