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 03/05/2013
NAME OF PROVIDER OR SUPPLIER ELKHART REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 MOREHOUSE AVE ELKHART, IN 46517	

(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	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). Survey Date: 03/05/13 Facility Number: 000243 Provider Number: 155352 AIM Number: 100289830 Surveyors: Joe L. Brown, Jr., Life Safety Code Specialist & Robert Sutton, Life Safety Code Specialist Trainee 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	K010000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	and 410 IAC 16.2. This one story facility was determined to be of Type IV (2HH) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, areas open to the corridors, and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 65 with a census of 49 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were not sprinklered including the garage, a shed, and the smoke tent. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/12/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the			

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	following:			

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K010018 SS=E	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 1¾ 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 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 3 of 34 resident room doors closed and latched into the door frame. This deficient practice had the potential to affect 14 residents in the north hall. Findings include: Based on observation on 03/05/13 with the Administrator during the tour from 9:30 a.m. to 4:00 p.m., the corridor doors to resident rooms 14, 18, and 19 would not latch into the door frame. Based on interview at the time of observation, the	K010018	K 018 The doors to rooms 14, 18 and 19 were adjusted to close andlatch. All doors were checked and closed appropriately. The preventive maintenance program was reviewed and doorfunction is assessed monthly. The maintenance director is responsible to assurecompliance. The administrator will check doors weekly X 4 and then monthly. Theaudit results will be reviewed monthly the Quality Assurance Committee andfurther action plans developed if indicated. Compliance date: April 4, 2013	04/04/2013

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	Administrator acknowledged the doors to resident rooms 14, 18, and 19 would not latch in the door frame. 3.1-19(b)			

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K010025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4			
	Based on observation and interview, the facility failed to ensure openings through 1 of 3 smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that 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 had the potential to affect 14 residents on the north hall, as	K010025	The penetrations in the smoke barriers were sealed. All other smoke barriers were sealed. Smoke barriers will be assessed for any penetration monthly. The Maintenance Director is responsible to assurecompliance. The Administrator or designee will review the preventativemaintenance audits monthly. The audit results will be reviewed monthly theQuality Assurance Committee and further action plans developed if indicated. Completion Date: March 11, 2013	03/11/2013

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	well as staff and visitors. Findings include: Based on observation on 03/05/13 with the Administrator during the tour from 9:30 a.m. to 4:00 p.m., there were two, one half inch holes in the smoke barrier on both sides of the smoke doors in the north hall adjacent to the Administrator's office. Based on interview at the time of observation, the Administrator acknowledged the penetrations in the smoke barrier were done by contractors and he would make sure the penetrations were sealed. 3.1-19(b)			

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K010027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 3 of 3 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice had the potential to affect all residents, staff and visitors in the facility. Findings include:	K010027	K 027 The smoke barrier doors were adjusted to close completely. All smoke doors are closing completely. The smoke door closure will be checked daily at least 5 X aweek for 4 weeks then weekly to assure compliance. The maintenance director is responsible to assurecompliance. The administrator will check doors weekly. The audit results willbe reviewed monthly the Quality Assurance Committee and further action plansdeveloped if indicated. Compliance date: April 4, 2013	04/04/2013

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	Based on observation on 03/05/13 with the Administrator during the tour from 9:30 a.m. to 4:00 p.m., the smoke barrier doors throughout the facility did not close completely, leaving a four and a half inch gap between the doors. Based on interview at the time of observation, the Administrator acknowledged the smoke barrier doors did not completely close, leaving a four and a half inch gap between the doors. 3.1-19(b)			

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K010048 SS=B	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 and interview, the facility failed to provide a written fire plan which included the use of kitchen fire extinguishers for the protection of 49 of 49 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (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 This deficient practice had the potential to affect any occupants in and near the kitchen and the adjoining dining room in the event of an emergency when the written	K010048	K 048 The information addressing the K-class fire extinguisher wasreplaced in the Emergency Policy Procedure Manual. All manuals were revised to have current information. The Emergency Policy Procedure Manual will be reviewed andrevised with any change and at least annually. The Administrator is responsible to assure manuals arecurrent and any changes will be reviewed monthly by the Quality AssuranceCommittee. Completion Date: April 4, 2013	04/04/2013

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	fire plan should be immediately available. Findings include: Based on record review and interview on 03/05/13 with the Administrator from 7:05 a.m. to 9:15 a.m., the policy and procedure for the written fire plan was found within the Emergency Policy Procedure manual, however, there was no information in the policy that addressed the K-class fire extinguisher usage. The Administrator stated he was unaware the procedure should address the K-class fire extinguisher usage. Based on interview at the time of record review, the Administrator acknowledged the information for the K-class fire extinguisher usage was not addressed in the emergency policy procedure manual. 3.1-19(b)			

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K010051 SS=E	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 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 Based on observation and interview, the facility failed to ensure smoke detectors connected to the fire alarm system in 1 of 3 smoke compartments were properly separated from an air supply. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice had the potential to affect residents in 1 of	K010051	K 051 The smoke detector located in the corridor near residentroom 27 and 28 was moved away from the air vent. All other smoke detectors were assessed and no others wereplaced by an air vent. If additional smoke detectors are installed the distancefrom the air vent will be observed. Completion Date: March 20, 2013	03/20/2013

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	3 smoke compartments as well as staff and visitors. Findings include: Based on observations and interview on 03/05/13 with the Administrator during the tour from 9:30 a.m. to 4:00 p.m., one smoke detector located in the corridor near resident room 27 and resident room 28 were approximately twelve inches from air vents. Based on interview at the time of observation, the Administrator confirmed the distances between the vents and agreed the air flow could interfere with smoke detector function. 3.1-19(b)			

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K010062 SS=D	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 1. Based on observation and interview, the facility failed to replace 1 of 1 sprinklers in the beauty shop which had paint on the deflector plate. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice had the potential to affect the resident and staff who use the beauty shop. Findings include: Based on observations and	K010062	K 062 The sprinkler head in the beauty shop was replaced. The sprinkler head in the men's bathroom was replaced. All other sprinkler heads were inspected and no others werein need of replacing. The sprinkler heads will be inspected by the MaintenanceDirector at least monthly and the contracted fire protection company at leastquarterly during the scheduled maintenance program. Results of the inspections will be reviewed monthly by theQuality Assurance Committee and further action plans developed if indicated. March 21, 2013	03/21/2013

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	interview on 03/05/13 with the Administrator during the tour from 9:30 a.m. to 4:00 p.m., the sprinkler head in the beauty shop had paint on the deflector plate. Based on interview at the time of observation, the Administrator acknowledged there was paint on the deflector plate of the sprinkler in the beauty shop. 3.1-19(b) 2. Based on observation and interview, the facility failed to replace 1 of 1 sprinklers in the men's bathroom adjacent to the beauty shop which had paint on the deflector plate. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires that any sprinkler shall be replaced which is painted, corroded,			

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	damaged, loaded, or in the improper orientation. This deficient practice had the potential to affect any resident, staff, or visitors who use the men's bathroom. Findings include: Based on observations and interview on 03/05/13 with the Administrator during the tour from 9:30 a.m. to 4:00 p.m., the sprinkler in the men's bathroom had paint on the deflector plate. Based on interview at the time of observation, the Administrator acknowledged there was paint on the sprinkler deflector plate in the men's bathroom. 3.1-19(b)			

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K010064 SS=E	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 Based on observation and interview, the facility failed to ensure 3 of 10 portable fire extinguishers were given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. This deficient practice had the potential to affect any residents, visitors and staff in the beauty shop, activity room, and the medical records room. Findings include:	K010064	K 064 The fire extinguishers in the beauty shop, activity room andmedical records were checked and the tag updated. All other fire extinguishers were checked and in compliancewith the monthly quick check A list of all extinguishers was developed to assure all arechecked monthly. The Maintenance Director is responsible to assure themonthly checks. The administrator will inspect at least 3 extinguishersmonthly. The audits will be reviewed monthly by the Quality Assurance Committeeand further action plans developed if indicated. Completion Date: April 4, 2013	04/04/2013

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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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	Based on observations and interview on 03/05/13 with the Administrator during the tour from 9:30 a.m. to 4:00 p.m., the annual maintenance tag attached to the portable fire extinguishers in the beauty shop, activity room, and medical records room did not show a monthly quick check for the portable extinguishers. Further, the last monthly quick checks performed on the fire extinguishers were performed on 09/2012. Based on interview at the time of observation, the Administrator acknowledged the monthly maintenance for the portable fire extinguishers was missed. 3.1-19(b)			

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K010066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (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. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (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 and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container which was provided for 1 of 1 areas where smoking was permitted. This deficient practice had the potential to affect any staff utilizing the designated employee smoking area adjacent to the resident dining area exit during a fire emergency.	K010066	K 066 The resident smoking area was cleaned and noncombustiblecontainers were provided for the residents use and all other containers wereremoved. There are no other designated smoking areas for theresidents The smoking area will be free of cigarette debris. The staffmembers assigned to supervise smoking will remind residents to use the	04/04/2013

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	Findings include: Based on observations and interview on 03/05/13 with the Administrator during the tour from 9:30 a.m. to 4:00 p.m., there were discarded cigarette butts by the exit door of the medical records room of the facility. Based on interview at the time of observation, the Administrator acknowledged the facility's employees disposed of cigarette butts on the ground. 3.1-19(b)		properdisposal container after smoking. The staff will be educated on use of thenoncombustible containers and cleanup of the area by the administrator ordesignee by April 4, 2013. The Life Enrichment Director will be responsible to inspectthe smoking area at least 3 times a week to assure compliance. None compliancemay result in removal of smoking privileges. The Quality Assurance Committeewill review the findings monthly and make further recommendations if indicated. Completion Date: April 4, 2013.	

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K010069 SS=E	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 commercial kitchen fire suppression systems was maintained. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations at 1.3.1 requires cooking equipment shall be maintained per the standard including the fire suppression system during all periods of operation of the cooking equipment. This deficient practice had the potential to affect occupants of the kitchen where 4 staff worked. Findings include: Based on record review and interview on 03/05/13 with the Administrator from 7:05 a.m. to 9:15 a.m., there was no current documentation provided showing maintenance of the fire suppression	K010069	K 069 The documentation showing the current maintenance of thehood suppression system is now available for review. The recommendation to addnave nozzles was followed and the revision completed. The routine maintenance of the hood suppression system isscheduled to be completed as required. The documentation of the maintenance and response to therecommendations will be maintained in the preventative maintenance binder. The maintenance director will be responsible to monitorcompletion using the TELS recording system and the Administrator will reviewcompliance concerns with the Quality Assurance Committee monthly and furtheraction plans developed if indicated. April 4, 2013	04/04/2013

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	system over the cooking equipment. Further record review indicated the contractor who performed the last cleaning recommended the swivels need to be added to nave nozzles so hey can be positioned correctly. Based on interview at the time of record review, the Administrator acknowledged there was no current documentation available showing maintenance for the fire suppression system over the cooking equipment and that the recommendations from the contractor have been performed. 3.1-19(b)			

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K010070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on observation, interview and record review; the facility failed to provide a policy for the use of 2 of 2 portable space heaters in the facility in accordance with NFPA 101, Section 19.7.8. This deficient practice is not in a resident care area but had the potential to affect all staff using the medical records room. Findings include: Based on observations and interview on 03/05/13 with the Administrator during the tour from 9:30 a.m. to 4:00 p.m., two space heaters were in use in the medical records room. During the record review process on 03/05/13 between 7:05 a.m. and 9:15 a.m., the facility's written policy stated space heaters are not allowed. Based on interview at the time of	K010070	K 070 Portable heating units in office spaces were removed. No other heating units were observed in the facility Office staff will be re educated on the policy of spaceheaters not being allowed. A PTAC unit has been ordered to provide acomfortable environment for the medical records staff. The maintenance director will be responsible to monitorcompliance during routine rounds and to address any noncompliance immediately. Completion Date: April 4, 2013	04/04/2013

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	observation, the Administrator acknowledged the usage of the space heaters in the medical records room. 3.1-19(b)			

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K010130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview, the facility failed to ensure a battery replacement program was provided to ensure 34 of 34 single station smoke detectors would operate. LSC 4.6.12.2. requires existing life safety features obvious to the public, if not required by this Code, shall either be maintained or removed. This deficient practice had the potential to affect all residents. Findings include: Based on record review on 03/05/13 with the Administrator between 7:05 a.m. and 9:15 a.m., the Preventive Maintenance Book did not have documentation indicating a battery replacement program for thirty four single station smoke detectors in resident rooms. Based on interview at the time of record review, the Administrator stated there is no battery replacement program for the	K010130	K 130 A system to monitor battery replacement for the thirty four smokedetectors in residents rooms has been added to the electronic preventativemaintenance program monitoring system (TELS). The 34 smoke detectors have a 5 year battery life andchecked monthly for function. The Maintenance Director is responsible for the monthlychecks and recording the function in the TELS program. To assure compliance the Administrator will review thedocumented checks monthly and report any concerns to the Quality AssuranceCommittee for further recommendations. Completion date: April 4, 2013	04/04/2013

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	single station smoke detector batteries. 3.1-19(b)			

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K010144 SS=F	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. 1. Based on record review and interview, for 12 of 12 months the facility failed to exercise the generator to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems. 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: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.	K010144	K 144 The documentation of the monthly generator test runningunder load now includes the record of the amperage and the percentage of loadcapacity. The record of weekly inspections of the generator startingbatteries is now in place. A remote manual stop for the generator was installed onMarch 19, 2013. The requirements for the generator function monitoring werereviewed and the record keeping process revised to reflect compliance. The Maintenance Director is responsible to assure compliancewith the preventative maintenance program and to record all information,. Theadministrator will review compliance monthly and report any concerns to theQuality Assurance Committee for further action plans if indicated. Completion Date: April 4, 2013	04/04/2013

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	The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice has the potential to affect all residents, staff and visitors. Findings include: Based on record review and interview on 03/05/13 with the Administrator from 7:05 a.m. to 9:15 a.m., the generator was run under load on a monthly basis but the amperage was not recorded and the percentage of load capacity was not recorded. Based on interview at the time of record review, the Administrator acknowledged the generator was checked on a monthly basis but the amperage was not recorded and the percentage of load capacity was not recorded. 3.1-19(b) 2. Based on record review and			

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	interview, the facility failed to ensure a written record of weekly inspections of the starting batteries for the generator was maintained for 25 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 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. Findings include:			

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	Based on record review on 03/05/13 with the Administrator from 7:05 a.m. to 9:15 a.m., the only documented dates of generator battery weekly inspections since the beginning of 2013 available for review were conducted since January. Additionally, per interview with the Administrator during the record review, there was no other documentation available for review to verify these weekly generator battery inspections were conducted. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with remote manual stops. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power			

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	Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice had the potential to affect all residents, staff and visitors. Findings include: Based on observations and interview on 03/05/13 with the Administrator during the tour from 9:30 a.m. to 4:00 p.m., a remote shut off device was not found for the generator. Based on interview at the time of observation, the Administrator acknowledged there			

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	was no emergency remote shut off device found for the generator. 3.1-19(b)			

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K010147 SS=B	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 facility failed to ensure extension cords including power strips and nonfused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 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 had the potential to affect all staff who uses the therapy and medical records office. Findings include: Based on observation and interview on 03/05/13 with the Administrator during the tour from 9:30 a.m. to 4:00 p.m., a refrigerator, water	K010147	K 147 The multiplug adaptor was removed from the Therapy Officeand the Medical Record office. All offices were inspected for use of multiplug adaptors asa substitute for fixed wiring. No others were identified. All office and therapy staff will be in serviced on the useof proper wiring. If equipment needs are identified fixed wiring will beinstalled to meet the electrical needs. Non compliance will result inprogressive corrective action up to and including termination. The maintenance director is responsible to identify anyconcerns during routine daily rounds and correct any non compliance. TheAdministrator will monitor during rounds and report any concerns to the QualityAssurance Committee for further action if indicated. April 4, 2013.	04/04/2013

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	cooler, and a microwave were plugged into a multiplug adaptor in the therapy office. Further, in the medical records room, an air conditioner and a portable heater were plugged into a multiplug adaptor. Based on interview at the time of observation, the Administrator acknowledged the use of a multiplug adaptors in the aforementioned areas. 3.1-19(b)			

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ELKHART REHABILITATION CENTER	2600 MOREHOUSE AVE ELKHART, IN 46517

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K010155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm 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 is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period to protect 49 of 49 residents in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the	K010155	K 155 The written procedure was revised to include the telephonenumbers of the ISDH and the local fire department. There were no other policy changes identified. Staff will be educated on the policy change and the firewatch process buy April 4, 2013. The policy change will be reviewed by the Quality AssuranceCommittee by April 4, 2013. Completion Date: April 4, 2013.	04/04/2013

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 03/05/2013
NAME OF PROVIDER OR SUPPLIER ELKHART REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 MOREHOUSE AVE ELKHART, IN 46517	

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	transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice had the potential to affect all residents, staff and visitors. Findings include: Based on record review and interview on 03/05/13 with the Administrator from 7:05 a.m. to 9:15 a.m., the fire watch procedure for an out of service automatic fire alarm system was not complete. The procedure lacked the required telephone numbers for the local fire department and the Indiana State Department of Health (317-233-5359). Based on interview at the time of record review, the Administrator acknowledged he had no other policy or procedure available to review.			

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 03/05/2013

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	3.1-19(b)			