

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155343	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/11/2015
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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LAGRANGE	STREET ADDRESS, CITY, STATE, ZIP CODE 0770 N 075 E LAGRANGE, IN 46761
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K 000  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: 05/11/15</p> <p>Facility Number: 000235 Provider Number: 155343 AIM Number: 100267740</p> <p>At this Life Safety Code survey, Life Care Center of LaGrange 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, in spaces open to the corridors and battery operated smoke detectors in all resident rooms. The facility has a capacity of 100 and had a census of 62 at the time of this survey.</p>	K 000	The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.	
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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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K 022 SS=D Bldg. 01	<p>All areas where the residents have customary access and all areas providing facility services were sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 1 of 1 Day Rooms containing a door that likely could be mistaken for a way of exit was identified as "No Exit". LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads: NO Exit. This deficient practice could affect staff, visitors, and any number of residents using the Day Room. Findings include: Based on observation with the Maintenance Manager and Maintenance Assistant on 05/11/15 at 1:04 p.m., the exterior door leading to the outside of the Day Room lacked a sign that identified the door either as an exit or not an exit. Based on interview at the time of</p>	K 022	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> No residents affected by the deficient practice. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> No residents affected by the deficient practice. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> The door in the day room now displays a "NO EXIT" sign. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> Since this is the only door in the facility that needed a sign posted "NO EXIT", the facility has corrected the issue and no further monitoring needed.</p>	06/10/2015

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K 025 SS=D Bldg. 01	<p>observation, the Maintenance Assistant said the door is not an exit but could be mistaken for one.</p> <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>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 5 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</p>	K 025	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> No residents affected by the deficient practice. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> No residents affected by the deficient practice. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> The 400 hall smoke barrier up in the attic was fixed the same day of the survey so the</p>	06/10/2015

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K 029 SS=D Bldg. 01	<p>for the specific purpose. This deficient practice could affect at least 30 residents as well as staff and visitors in two of five smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with Maintenance Manager and Maintenance Assistant on 05/11/15 at 2:35 p.m. the 400 hall smoke barrier wall had an unsealed penetration above the ceiling tile which was a ¼ inch opening to allow internet cables to pass through. Based on interview, this was acknowledged by the Maintenance Manager at the time of observation.</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 permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 kitchens, a hazardous area, was</p>	K 029	<p>penetration was sealed up. An audit was done to check the other four smoke barriers to make sure they were in compliance. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> The inspection of the smoke barrier walls in the attic will be added to the facilities preventative maintenance program. The maintenance director or designee will inspect the barriers monthly and after contractors perform work up in the attic. The results will be forwarded to the facility performance improvement committee for further evaluation or resolution.</p> <p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the</p>	06/10/2015

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	<p>provided with self closer and would latch into the frame. This deficient practice was not in a resident care but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation and interview on 05/11/15 at 2:04 p.m., the Maintenance Manager and Maintenance Assistant confirmed the corridor door entering the kitchen from the service hall had a manual slide bolt which did not self close and positively latch into the frame.</p> <p>3.1-19(b)</p>		<p>following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> No residents affected by the deficient practice. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> No residents affected by the deficient practice. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> The facility has placed an order for a self-closer that positively latches into the frame for the kitchen door. Once the facility receives the closer, the facility will install it on the kitchen door. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> Since this is the only corridor door in the facility that has to have a self-closer which positively latches into the frame, the facility has corrected the issue and no further monitoring is needed.</p>				
K 062 SS=C Bldg. 01	<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 sprinkler systems was continuously maintained in reliable operating condition</p>	K 062	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The</i></p>	06/10/2015			

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	<p>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 Manager and Maintenance Assistant on 05/11/15 at 2:13 p.m., the sprinkler system located in the sprinkler riser room had four pressure gauges with a date indicating the gauges were manufactured in 2010. Based on interview at the time of observation, the Maintenance Manager and Maintenance Assistant acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 7 of 7 corroded sprinklers in the Front Entry Awning and Front Entry Lobby Men's Bathroom. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in</p>		<p><i>corrective action taken for the residents found to have been affected by the deficient practice was:</i> No residents affected by the deficient practice. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> No residents affected by the deficient practice. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> The pressure gauges for the sprinkler system were replaced on 5/13/2015. The seven sprinklers (6 in the front entry awing and 1 in the men's bathroom have been ordered and will be replaced once they arrive to the facility. The facility had a contractor come in to perform the five year inspection on 5/13/2015. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> A performance indicator has been established which will evaluate compliance with replacement of the gauges, sprinkler heads, and the five year inspection. The sprinkler head indicator will be completed by the maintenance director or designee monthly for the first quarter and then semi-annually thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution.</p>				

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	<p>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 was not located in a patient treatment area but could affect any residents, staff, or visitors using the Front Entry.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Manager and Maintenance Assistant on 05/11/15 at 2:24 p.m. and at 2:26 p.m., six sprinklers in the Front Entry Awning and one sprinkler in the Front Entry Lobby Men's Bathroom were corroded with a green substance. Based on interview at the time of each observation, the Maintenance Manager and Maintenance Assistant acknowledged the condition of the sprinkler heads.</p> <p>3. Based on record review and interview, the facility failed to ensure 1 of 1 automatic dry sprinkler piping systems was inspected every five years as required by NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems</p>			

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K 064 SS=D Bldg. 01	<p>10-2.2. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Manager and Maintenance Assistant on 05/12/15 at 11:22 a.m., the Shambaugh and Son L.P. sprinkler report documented on 03/02/15 that, " Air compressor - This device runs every 2 min and an air test or internal is needed." Previous sprinkler inspection dated 02/22/10 was the last time an internal inspection had been performed. Based on an interview with the Maintenance Manager and Maintenance Assistant at the time of record review, he stated the internal inspection has been already scheduled.</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 2 of 3 Mechanical room portable fire extinguishers requiring a 12 year hydrostatic test were emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for</p>	K 064	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> No residents affected by the</p>	06/10/2015

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K 147 SS=B Bldg. 01	<p>Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Manager and Maintenance Assistant on 05/11/15 at 12:28 p.m. and at 1:51 p.m., documentation on the portable fire extinguisher located in the 100 Hall Mechanical room and the portable fire extinguisher in the Main Hall Mechanical room indicated both fire extinguishers last internal inspection was 2008. The Maintenance Manager and Maintenance Assistant acknowledged the date on each extinguisher.</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</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 outlets in the Maintenance Shop Bathroom #2 was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas that are</p>			K 147	<p>deficient practice. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> No residents affected by the deficient practice. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> The two fire extinguishers were inspected by the contractor on 5/14/2015. They also inspected all other fire extinguishers to make sure all were in compliance. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> The fire extinguishers were put on an internal inspection program. The maintenance director of designee will perform monthly checks with results forwarded to the facility performance improvement committee for further evaluation or resolution.</p> <p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> The multiplug adapter in resident room 413 was removed</p>		06/10/2015

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	<p>subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Manager and Maintenance Assistant on 05/11/15 at 12:22 p.m., an electric receptacle was on the wall within three feet of the bathroom sink in Maintenance Shop Bathroom #2. When testing the receptacle, the outlet failed the trip test by not cutting off power to the outlet. Based on interview at the time of observation, the Maintenance Manager and Maintenance Assistant acknowledged the aforementioned test and added the Maintenance Office is being remodeled.</p> <p>3.1-19(b)</p>		<p>that same day. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> A facility wide audit of all resident rooms was completed to make sure no other adaptors were being used. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> The GFCI receptacle has been replaced and in good working condition. The coffee pot was removed that day. One of the power strips in the main hall mechanical room was removed that day along with one of the power strips in the environmental service room was removed that same day. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> A performance indicator has been established which will evaluate compliance with GFCI receptacles, multiplug adaptors, and power strips. The maintenance director or designee will complete the indicator weekly for the first month and then monthly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution.</p>		

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	<p>2. Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords such as extension cord power strips were not used as a substitute for fixed wiring. 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 staff and 2 residents.</p> <p>Findings include: Based on an observation with the Maintenance Manager and Maintenance Assistant on 05/11/15 between 1:05 p.m. and 2:19 p.m., the following was discovered:</p> <p>a) Coffee pot was plugged into a surge protector in the Director of Nursing office.</p> <p>b) Multiplug adapter powering two televisions, cable box, and cell phone charger in resident room 413</p> <p>c) Powerstrips were plugged in and powering other powerstrips in the Main Hall Mechanical Room</p> <p>d) Powerstrips were plugged in and</p>			

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	powering other powerstrips in the Environmental Service Room Based on interview at the time of each observation, the Maintenance Manager and Maintenance Assistant acknowledged each aforementioned condition. 3.1-19(b)				