

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155596	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/30/2015
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NAME OF PROVIDER OR SUPPLIER LAKELAND SKILLED NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703
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(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
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K 0000 Bldg. 02	<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: 06/30/15</p> <p>Facility Number: 000474 Provider Number: 155596 AIM Number: 100290510</p> <p>At this Life Safety Code survey, Lakeland Skilled Nursing and Rehabilitation 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) and 410 IAC 16.2. The original building consisting of the 200, 300 halls and the service hall were surveyed with Chapter 19, Existing Health Care Occupancies.</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 and areas open to the corridors. The resident rooms on the 300 hall and</p>	K 0000	<p>This Plan of Correction is the centers 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 al- leged 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.</p>	
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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 0025 SS=E Bldg. 02	<p>400 hall had hard wired smoke detectors. The resident rooms on the 200 hall had battery operated smoke detectors. The facility has a capacity of 75 and had a census of 60 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had a detached shed providing facility services including maintenance supplies that was not sprinklered.</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 1 of 1 ceiling smoke barriers was maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. LSC Section 8.3.6.1</p>	K 0025	The ceiling penetrations in the 400 hall maintenance room and 400 hall electrical room were replaced with approved red caulk on 7-8-15. Documentation of the approved caulk is kept in the Maintenance Directors office. An audit was conducted on 7-1-15 of wall penetrations. There were no	07/30/2015

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	<p>requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice can affect 20 residents in the 200 hall.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with Maintenance Director on 06/30/15 from 10:20 a.m. to 12:00 p.m., the following locations had penetrations sealed with an unapproved material in the ceiling smoke barrier:</p> <p>a) in the ceiling of the 200 hall maintenance room two penetrations were sealed with a yellow caulk.</p> <p>b) in the ceiling of the 200 hall electrical room eight penetrations were sealed with a yellow caulk.</p> <p>Based on an interview at the time of observation, the Maintenance Director did not know if the yellow caulk was an approved material and did not have the documentation to show the caulk met the requirements for use in through penetration fire stop systems.</p> <p>3.1-19(b)</p>		<p>further penetrations found with unauthorized caulk. Weekly inspections of fire wall penetrations will be made by the Maintenance Director for 4 weeks. If no other finding within the four weeks the inspections will occur monthly for five months. Any unauthorized caulk found will be fixed immediately. All weekly/monthly inspections will be presented to and reviewed by the Business Leadership Team, a part of the Quality Assurance Committee. If no further issues are presented, the Quality Assurance Committee, responsible to the Administrator, will review quarterly for continued compliance.</p>				

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K 0029 SS=E Bldg. 02	<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 the corridor door to 1 of 1 storage rooms with combustibles, measuring over 50 square feet in size, were provided with a self closing device. This deficient practice could affect 20 residents on the 200 hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 06/30/15 at 10:33 a.m., the corridor door to the medical records room measuring over 50 square feet in size which contained 43 boxes of paper, lacked a self closing device. Based on interview, this was confirmed by the Maintenance Director at the time of observations.</p>	K 0029	<p>A self closing device was installed on the 200 hall medical records storage room on 7-1-15 Audit completed on 7-1-15of any other rooms that were 50 square feet in size and contained combustibles. No further issues found. The Maintenance Director will monitor the new self closing door weekly for proper adjustment for four weeks. If there are no further issues, the door will be reviewed on a monthly basis by the Maintenance Director for 5 months The Maintenance Director will submit the weekly/monthly reviews to the Quality Assurance Committee, responsible to the Administrator, for review and monitoring for continued compliance.</p>	07/30/2015

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K 0062 SS=E Bldg. 02	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to replace 2 of 3 automatic sprinklers in the 200 hall resident's bath which was corroded. 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 could affect 20 residents in the 200 hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 06/30/15 at 10:15 a.m., there were two automatic sprinklers corroded with a green substance located in the 200 hall resident's bath. Based on interview at the</p>	K 0062	The sprinkler heads in the 200 hall shower room were replaced on 7-8-15. The sprinkler head in the front foyer missing the an escutcheon was also fixed on 7-8-15 An audit was completed on all sprinklers on 7-8-15. An audit of sprinkler heads will be completed on a monthly basis for the next six months and any broken or corroded sprinklers will be replaced. Maintenance Director will submit the monthly audit to the Business Leadership Team on a monthly basis for review of continued compliance. The Business Leadership Team will submit the audits to the Quality Assurance Committee, responsible to the Administrator, on a quarterly basis for continued compliance for the next two quarters.	07/30/2015			

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K 0064	<p>time of the observation, the Maintenance Director acknowledged the sprinkler heads were corroded.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinklers in the front foyer was properly maintained. 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. This deficient practice can affect any residents using the front exit.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 06/30/15 at 9:15 a.m., the sprinkler in the front foyer was missing an escutcheon. Based on interview at the time of observation, this was acknowledged by the Maintenance Director.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>			

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SS=E Bldg. 02	<p>LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguishers located in the Beauty Shop was mounted so the top of the extinguisher was no more than five feet (60 inches) above the floor. NFPA 10, Section 1-6.10 requires fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than 5 feet (60 inches) above the floor. This deficient practice affects 4 residents using the beauty shop.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 06/30/15 at 11:05 a.m., the fire extinguisher mounted on the wall in the Beauty Shop measured six feet from the floor to the top of the fire extinguisher. Based on an interview at the time of observation, the Maintenance Director provided the measurements for the height of the fire extinguisher.</p> <p>3.1-19(b)</p>	K 0064	The fire extinguisher mounted in the Beauty Shop was lowered to not more than 5 feet above the floor on 7-1-15. An audit of all fire extinguishers was completed on 7-2-15. No other extinguishers were found out of compliance. An audit of fire extinguishers will be completed on a monthly basis for the next six months and any found to be mounted higher than 5 feet will be lowered to the appropriate level. Maintenance Director will submit the monthly audit to the Business Leadership Team, a part of the Quality Assurance Committee, for review of continued compliance. The Business Leadership Team will submit the audits to the Quality Assurance Committee, responsible to the Administrator, on a quarterly basis for continued compliance for the next two quarters.	07/30/2015			
K 0130	NFPA 101						

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SS=E Bldg. 02	<p>MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation, record review and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment, or system required for compliance with this Code shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 40 residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation and record review of the Bradly Overhead Door Report with the Maintenance Director on 06/30/15 at 11:19 a.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room. According to the report, the last annual inspection was</p>	K 0130	The rolling fire door located between the kitchen and the dining room was inspected on 7-2-15 and is in proper working order. The rolling fire door is included on the monthly fire drill form and is monitored during each active fire drill for proper functioning. Any malfunction is reported to the Maintenance department and will be repaired immediately. Maintenance Director added the rolling door to his preventative maintenance list for yearly inspections on 7-2-15. All fire drills and Preventative Maintenance yearly inspections will be submitted monthly by the Maintenance Director to the Quality Assurance Committee for the next six months. Quality Assurance Committee, who reports to the Administrator will monitor for continued compliance over the next two quarters.	07/30/2015			

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K 0000 Bldg. 03	<p>conducted on 10/02/13. Based on interview with the Maintenance Director at the time of observation, no other documentation was available for review.</p> <p>3.1-19(b)</p> <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: 06/30/15</p> <p>Facility Number: 000474 Provider Number: 155596 AIM Number: 100290510</p> <p>At this Life Safety Code survey, Lakeland Skilled Nursing and Rehabilitation 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) and 410 IAC 16.2. The new 2012 addition of the 400 hall was surveyed with Chapter 18, New Health Care Occupancies.</p>	K 0000	This Plan of Correction is the centers 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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K 0025 SS=E Bldg. 03	<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 and areas open to the corridors. The resident rooms on the 300 hall and 400 hall had hard wired smoke detectors. The resident rooms on the 200 hall had battery operated smoke detectors. The facility has a capacity of 75 and had a census of 60 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had a detached shed providing facility services including maintenance supplies that was not sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-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 in approved 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. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide</p>	K 0025	The ceiling penetrations in the 400 hall maintenance room and 400 hall electrical room were replaced with approved red caulk	07/30/2015

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	<p>a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice can affect 16 residents in the 400 hall.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with Maintenance Director on 06/30/15 from 10:20 p.m. to 12:00 p.m., the following locations had unsealed penetrations or penetrations sealed with an unapproved material in the ceiling smoke barrier:</p> <ul style="list-style-type: none"> a) in the ceiling of the 400 hall storage room 20 penetrations were sealed with a yellow caulk. b) in the ceiling of the 400 hall electrical room 20 penetrations were sealed with a yellow caulk. c) in the ceiling of the 400 hall storage room there were three unsealed penetrations measuring one half of an inch around wires running through metal 		<p>on 7-8-15. Documentation of the approved caulk is kept in the Maintenance Directors office. An audit was conducted on 7-1-15 of wall penetrations. There were no further penetrations found with unauthorized caulk. Weekly inspections of fire wall penetrations will be made by the Maintenance Director for 4 weeks. If no other finding within the four weeks the inspections will occur monthly for five months. Any unauthorized caulk found will be fixed immediately. All weekly/monthly inspections will be presented to and reviewed by the Business Leadership Team, a part of the Quality Assurance Committee. If no further issues are presented, the Quality Assurance Committee, responsible to the Administrator, will review quarterly for continued compliance.</p>	

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	<p>pipes. d) in the ceiling of the 400 hall electrical room were two unsealed penetrations measuring one and a half inches to one eighth of an inch around wire and a sprinkler line. Based on interview at the time of observation, the Maintenance Director did not know if the yellow caulk was an approved material and did not have the documentation to show the caulk met the requirements for use in through penetration fire stop systems. Also, the Maintenance Director acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p>				