

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 05/12/2016
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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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K 0000 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: 05/12/16</p> <p>Facility Number: 000243 Provider Number: 155352 AIM Number: 100289830</p> <p>At this Life Safety Code survey, Elkhart Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type III (200) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. Battery operated smoke detectors are provided in the resident sleeping rooms. The facility has a capacity of 58 with a census of 34 at the</p>	K 0000	<p>This plan of correction is submitted as Elkhart Rehabilitation Center's written Credible Allegation of Compliance for the deficiencies cited. The submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana State Department of Health's Inspection report. Elkhart Rehabilitation Center respectfully requests consideration for a desk review of this Plan of Correction.</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.

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K 0029 SS=E Bldg. 01	<p>time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except the garage, a shed, and the smoke tent.</p> <p>Quality Review completed on 05/16/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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>1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Kitchen, a hazardous area, was provided with self-closer and would latch into the frame. This deficient practice could affect staff and 15 resident.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the Executive Director on 05/12/16 at 12:05</p>	K 0029	<p>It is the practice of this facility that doors leading to the corridor latch and are equipped with self-closing hardware</p> <p>CORRECTIVE ACTION: 1 The kitchen door cited had self-closing hardware repaired to ensure that door closes appropriately when not in use 2 The door to the laundry room had self-closing hardware and the door handle/latch was replaced to ensure that it latches into the door frame when closed HOW OTHERS IDENTIFIED: All doors</p>	05/26/2016

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	<p>p.m., the Kitchen room contained fuel fired appliances. One of the set of corridor doors had a manual door latch and did not contain self-closing hardware. Based on interview at the time of observation, the Maintenance Supervisor and the Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 fuel fired Laundry, a hazardous area, was provided with self-closer and would latch into the frame. This deficient practice could affect staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the Executive Director on 05/12/16 at 11:44 a.m., the Laundry room contained fuel fired appliances. The corridor door in the Laundry room did not contain self-closing hardware. Based on interview at the time of observation, the Maintenance Supervisor and the Executive Director acknowledged the aforementioned condition.</p>		<p>leading to "hazardous" areas have been inspected to ensure they have self-closure hardware as needed MEASURES TO PREVENT: Doors equipped with self-closure hardware will be inspected monthly to ensure they function appropriately MONITORING: Maintenance Director and/or Designee will inspect all doors equipped with self-closure hardware to ensure that they are functioning appropriately The inspection will occur weekly x4 weeks; then monthly for 5 months, and then quarterly Any deficient practice will be monitored through monthly Continuous Quality Improvement process until it reaches 100% compliance</p>	

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K 0050 SS=F Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>1. Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 1 of the last 4 calendar quarters. This deficient practice could affect all staff and residents.</p> <p>Findings include: Based on record review of the "Monthly Fire Drill Report" forms with the Maintenance Supervisor and the Executive Director of the fire drill reports titled "Monthly Fire Drill Report" on 05/12/16 at 9:51 a.m., the documentation for a first shift fire drill for the first quarter of 2015 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor and the Executive Director</p>	K 0050	<p>It is the practice of this facility that Fire Drills be held at unexpected times under varying conditions, at least quarterly on each shift</p> <p>CORRECTIVE ACTION:</p> <p>1 Monthly Fire Drills are being conducted and recorded at varying times on each shift at least quarterly The Fire Drills that were cited were not able to be located for the first quarter as they were in the TEL's system of the previous company This has been corrected and the Fire Drills are being kept in the Preventative Maintenance Log The schedule in place ensures that the fire drills are conducted at varying times</p> <p>2 The schedule in place will ensure that the time Fire Drills are conducted will be sufficiently spaced to ensure they are not predictable</p> <p>HOW OTHERS IDENTIFIED:</p>	05/26/2016

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K 0062 SS=F Bldg. 01	<p>acknowledged the lack of documentation.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all staff and residents.</p> <p>Findings include:</p> <p>Based on record review of the "Monthly Fire Drill Report" forms with the Maintenance Supervisor and the Executive Director on 05/12/16 at 9:51 a.m., three sequential second shift fire drills took place between 8:55 a.m. and 9:35 a.m. for three of the last four quarters. Then again, three sequential third shift fire drills took place between 4:36 a.m. and 5:30 a.m. for three of the last four quarters. Based on interview at the time of record review, the Maintenance Supervisor and the Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating</p>		<p>Utilizing the new schedule will ensure that everyone in the facility that was affected will be addressed</p> <p>MEASURE TO PREVENT: Utilizing the schedule will ensure that the criteria for conducting the Fire Drills at varying times under varying conditions will occur as required</p> <p>MONITORING: Executive Director and/or designee will monitor the Fire Drills on a monthly basis to ensure that they are being conducted per the schedule This information will be reviewed monthly at the CQI meetings Any deficient practice will be monitored through Continuous Quality Improvement process until it reaches 100% compliance</p>				

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	<p>condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 requires sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect all occupants if the sprinkler system is damaged.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and the Executive Director on 05/12/16 between 11:52 a.m. and 11:59 a.m., the following was discovered on sprinkler piping:</p> <p>a. Ice buildup at least one inch thick in the walk-in freezer</p> <p>b. Twenty four inches of foam padding in the walk-in freezer</p> <p>c. At least twenty five zip ties holding at least three cables throughout the Kitchen</p> <p>d. A security camera zip tied to the sprinkler pipe in the Kitchen</p> <p>Based on interview at the time of each observation, the Maintenance Supervisor and the Executive Director acknowledged the aforementioned condition.</p>	K 0062	<p>It is the practice of this facility that the Sprinkler System not support non-system components</p> <p>CORRECTIVE ACTION:</p> <p>a The ice build up was removed from the pipes</p> <p>b Foam insulation padding was removed from the pipe</p> <p>c The zip ties and wiring was removed from the sprinkler pipe in the kitchen</p> <p>d The security camera was removed fro the sprinkler pipe in the kitchen</p> <p>HOW OTHERS IDENTIFIED:</p> <p>All sprinkler pipes were inspected to ensure that they do not have any non-system components attached to them</p> <p>PREVENTATIVE MEASURES:</p> <p>Preventative Maintenance plan will be initiated to ensure that there are no non-system components attached or secured to the sprinkler system</p> <p>MONITORING:</p> <p>Maintenance Director and/or designee will monitor Sprinkler system to ensure that non-system components are not attached or secured to the sprinkler system</p> <p>Sprinkler System will be monitored weekly x 4 weeks; then bi-weekly for 4 weeks; then monthly The system will continue to be monitored for 6 months and then quarterly thereafter</p> <p>Any deficient practice will be monitored through</p>	05/26/2016			

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K 0064 SS=D Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Medical Record fire extinguishers requiring a 12-year hydrostatic test was emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect staff and up to 3 residents.</p> <p>Findings include:</p> <p>Based on observation and interview with the Maintenance Supervisor and the Executive Director on 05/12/16 at 12:23 p.m., the Medical Record fire extinguisher maintenance tag indicated the last six year test was completed 11/09. Based on interview at the time of observation, the Maintenance Supervisor and the Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0064	<p>Continuous Quality Improvement process until it is 100% compliant</p> <p>It is the practice of this facility that portable fire extinguishers shall be installed inspected, and maintained CORRECTIVE ACTION: The fire extinguisher cited was removed and replaced at the time of observance with a fire extinguisher that was in compliance with the requirement HOW OTHERS IDENTIFIED: Contracted vendor took all the in-house fire extinguishers for required maintenance on 5/17/16 PREVENTATIVE MEASURES: This addressed all the fire extinguishers in the facility A log of needed maintenance will be placed in the front of preventative maintenance log to ensure that fire extinguishers are being maintained as required MONITORING: Maintenance Director and/or designee will monitor the Fire extinguishers to ensure the required maintenance is conducted per schedule Extinguishers will be placed on a Log indicating when required maintenance is due to ensure it is being conducted as needed The log will be monitored monthly to</p>	05/26/2016			

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K 0144 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 3-6.4.1.1 Maintenance and Testing Transfer Switches states the general shall be maintained as to be capable of supplying service with the shortest time practical and within 10 seconds. This deficient practice could affect all staff, residents, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor and the Executive Director on 05/12/16 at 10:51 a.m., the monthly testing forms indicated the transfer time for nine months of the last twelve months of testing were twenty seconds or higher. Based on interview at the time of record review, the</p>	K 0144	<p>ensure that all required inspections and/or maintenance have been conducted Any deficient practice will be monitored through Continuous Quality Improvement process until it reaches 100% compliance</p> <p>It is the practice of this facility that the generator is inspected weekly and exercised under load for 30 minutes per month CORRECTIVE ACTION: IEI was contacted to test the generator to ensure that the transfer time is within the required 10 seconds; scheduled to be here on 5/25/16 HOW OTHERS IDENTIFIED: Ensuring that the transfer time is within the 10 seconds will address all those affected PREVENTATIVE MEASURES: The weekly and monthly generator checks will continue to be conducted in accordance with the Preventative Maintenance plan MONITORING: Maintenance Director and/or Designee will monitor: 1 the generator logs will be monitored on a monthly basis to ensure that they are being conducted per the schedule This information will be reviewed monthly at the CQI</p>	05/26/2016

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	<p>Maintenance Supervisor and the Executive Director acknowledged the aforementioned condition.</p> <p>3-1.19(b)</p> <p>2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 3 of the last 12 months. 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, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. 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 for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the generator</p>		<p>meetings 2 the monthly generator documentation that were cited were not able to be located for the first quarter as they were in the TEL's system of the previous company This has been corrected and the Monthly Generator logs are being kept in the Preventative Maintenance log Any deficient practice will be monitored through Continuous Quality Improvement process until it reaches 100% compliance</p>		

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K 0211 SS=E Bldg. 01	<p>log "Monthly Load Test Log" with the Maintenance Supervisor and the Executive Director on 05/12/16 at 10:51 a.m., there was no documentation of a generator load test for prior to August 2015. None of the load test information was filled out on 03/4/16. Based on an interview with the Maintenance Supervisor and the Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers shall have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. <p>18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 alcohol based hand sanitizers in Therapy was not installed above or near an ignition source. NFPA 101, in 19.1.1.3 requires all health</p>	K 0211	<p>It is the policy of this facility that alcohol based hand sanitizers are not installed above or an ignition source</p> <p>CORRECTIVE ACTION: The hand sanitizer unit cited was</p>	05/26/2016			

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	<p>facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect staff and up to 11 patients.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the Executive Director on 05/12/16 at 11:22 a.m., an alcohol based hand sanitizer dispenser was mounted on the wall above an outlet in the Therapy. The dispenser drip location was one inch away from the outlet. Based on interview at the time of observation, the Maintenance Supervisor and the Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>removed at the time of observance</p> <p>HOW OTHERS IDENTIFIED: Building wide audit was conducted to ensure that there were not other alcohol based hand sanitizers installed above or near an ignition source</p> <p>PREVENTATIVE MEASURES: No alcohol based hand sanitizers will be installed without first being approved by Maintenance Director and/or Executive Director to ensure compliance</p> <p>MONITORING: Maintenance Director and/or Designee will conduct monthly rounds will be conducted to ensure there have been no installation of alcohol based hand sanitizers dispensers</p>		