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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155477 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>09/23/2015 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>LANE HOUSE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1000 LANE AVE<br>CRAWFORDSVILLE, IN 47933 |
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| K 0000<br><br>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: 09/23/15</p> <p>Facility Number: 000462<br/>Provider Number: 155477<br/>AIM Number: 100275380</p> <p>At this Life Safety Code survey, Lane House 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 with two partial basements was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has</p> | K 0000 | <p>This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the survey's findings or conclusions are accurate, that the findings constitutes deficiencies, or that the scope and severity regarding the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance for the citation listed. We do ask at this time for consideration for paper compliance for the corrected citations.</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 0020<br>SS=E<br>Bldg. 01 | <p>a capacity of 60 and had a census of 48 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached buildings providing storage services one of which includes an oxygen storage and transfilling building which were each not sprinklered.</p> <p>Quality Review completed 09/24/15 - DA</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p> <p>Based on observation and interview, the facility failed to enclose 1 of 1 stairwell vertical openings inside the facility with construction having a fire resistance rating of one hour. This deficient practice could affect 20 residents, staff and visitors in the smoke compartment adjoining the stairwell by the main entrance lounge.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Director of Plant Services during a tour of the facility from</p> | K 0020        | <p>Immediate Correction Facility has contacted two door suppliers to order and have installed the 1 hour fire rated door to replace the identified door to the stairwell. It will take more than 30 days for the door to be available and installed, but should not exceed 90 days. We respectfully request an extension of time to not exceed a completion date of December 15, 2015 for the installation of the 1 hour fire rated stairwell door. Additional smoke detection has been installed in the stairwell on 9-30-15 to help abate any risk while awaiting the new door. The stairwell is also covered by sprinklers and there is</p> | 12/15/2015           |

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| K 0033<br>SS=E<br>Bldg. 01                       | <p>11:30 a.m. to 1:15 p.m. on 09/23/15, the stairwell door at the top of the stairwell by the main entrance lounge had an affixed fire resistance label stating the door had a 20 minute fire resistance rating. Based on interview at the time of observation, the Director of Plant Services acknowledged the aforementioned stairwell door failed to maintain a fire resistance rating of one hour for the stairwell vertical opening.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building.<br/>8.2.5.2, 19.3.1.1</p> <p>Based on observation and interview, the facility failed to enclose 1 of 1 exit stairwells inside the facility with construction having a fire resistance rating of one hour. This deficient practice could affect 20 residents, staff and visitors in the smoke compartment</p> | K 0033  | <p>a steel door at the base of the stairs that is kept closed. The stairwell is concrete and there is no flammable material stored within the stairwell. <b>Identification of Others Potentially Affected</b> There are no other identified areas affected. <b>Measures and / or Systemic Changes</b> The Director of Plant Services was provided education (Document 1) on the proper fire rating of doors leading into a stairwell to ensure any door replaced or added in the future meet the code. <b>Monitoring/ Quality Assurance</b> Any new installation or replacement door(s) will be checked by the DOPS or designee prior to installation to ensure fire rating present and up to code for the area of installation.</p> <p>Immediate Correction Facility has contacted two door suppliers to order and have installed the 1 hour fire rated door to replace the identified door to the stairwell. It will take more than 30 days for the door to be available and installed, but should not exceed 90 days. We respectfully request</p> | 12/15/2015   |  |   |  |

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| K 0052<br>SS=F<br>Bldg. 01                       | <p>adjoining the stairwell by the main entrance lounge.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Director of Plant Services during a tour of the facility from 11:30 a.m. to 1:15 p.m. on 09/23/15, the stairwell door at the top of the stairwell by the main entrance lounge had an affixed fire resistance label stating the door had a 20 minute fire resistance rating. Based on interview at the time of observation, the Director of Plant Services acknowledged the aforementioned stairwell door failed to enclose the exit stairwell with a fire resistance rating of one hour.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of</p> |   | <p>an extension of time to not exceed a completion date of December 15, 2015 for the installation of the 1 hour fire rated stairwell door. Additional smoke detection has been installed in the stairwell on 9-30-15 to help abate any risk while awaiting the new door. The stairwell is also fully covered with the existing sprinkler system and there is a steel door at the base of the stairs that is kept closed. The stairwell is concrete and there is no flammable material stored within the stairwell. <b>Identification of Others Potentially Affected</b> There are no other identified areas affected. <b>Measures and / or Systemic Changes</b> The Director of Plant Services was provided education (Document 1) on the proper fire rating of doors leading into a stairwell to ensure any door replaced or added in the future meet the code. <b>Monitoring/ Quality Assurance</b> Any new installation or replacement door(s) will be checked by the DOPS or designee prior to installation to ensure fire rating present and up to code for the area of installation.</p> |  |  |   |  |

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|  | <p>NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review, observation and interview; the facility failed to ensure all smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked); the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method</li> <li>(2) Manufacturer's calibrated sensitivity test instrument</li> <li>(3) Listed control equipment arranged for the purpose</li> </ol> | K 0052  | <p>Immediate Correction B &amp; R Fire Protection Company was called back to the facility on 9/25/15 (Document 2) and they performed the applicable testing on the four additional fire alarm system smoke detectors that were not tested originally on 9/2/15 (Document 3). <b>Identification of Others Potentially Affected</b> Not applicable- no other non-compliance identified <b>Measures &amp;/or Systemic Changes</b> A Master identification form (Document 4) was created to identify the number and location of all fire alarm system smoke detectors, currently 34 in number. This master list will be used during the subsequent testing as a cross reference to prevent missing detectors to be tested in the future. The Director of Plant Services or designee will meet with the testing company prior to and at the completion of the testing to review the master list and then compare to the testing companies list. Any discrepancies will be identified and corrected. In addition, the master identification form identifies when the last test was completed, and when the next testing is due by. This will ensure timely completion of the testing moving forward.</p> <p><b>Monitoring/Quality Assurance</b><br/>The master identification list will be reviewed and compared to the actual testing report during the</p> | 10/01/2015   |  |   |  |

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|  | <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</p> <p>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of B&amp;R Fire Protection Company "Smoke Detector Sensitivity Test Report" documentation dated 09/02/15 with the Director of Plant Services during record review from 9:30 a.m. to 11:30 a.m. on 09/23/15, it could not be assured sensitivity testing documentation included all facility fire alarm system smoke detectors. The aforementioned documentation stated there are a total of 28 fire alarm system smoke detectors installed in the facility which were all tested and passed sensitivity testing on 09/02/15. B&amp;R's sensitivity testing documentation dated 01/10/13 stated 30 fire alarm system smoke detectors were tested and passed. Thirty five smoke detectors were</p> |   | 1st PI meeting following each testing date to monitor for compliance. In addition, the master identification list will be brought to each Q/A meeting for review to ensure compliance with the next scheduled testing date. This will be an ongoing system with no end date. |  |  |   |  |

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| K 0056<br>SS=D<br>Bldg. 01 | <p>sensitivity tested by B&amp;R in 2011 sensitivity testing documentation. Based on interview at the time of record review, the Director of Plant Services stated he was unaware of any facility fire alarm system smoke detectors being removed from the facility within the most recent two year period. Based on observation with the Director of Plant Services at 1:30 p.m. on 09/23/15, south basement storage rooms were provided with facility fire alarm system smoke detectors. Based on interview at the time of observation, the Director of Plant Services stated not all basement storage room facility fire alarm smoke detectors were sensitivity tested by B&amp;R on 09/02/15 and acknowledged sensitivity testing documentation for all facility fire alarm system smoke detectors within the most recent two year period was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13,</p> |               |   |                      |

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|                    | <p>Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure the sprinkler system was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect 5 staff and visitors in the vicinity of the milk cooler storage room in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Director of Plant Services during a tour of the facility from 11:30 a.m. to 1:15 p.m. on 09/23/15, a 48 inch horizontal length of steel sprinkler pipe installed in the milk cooler storage</p> | K 0056        | <p>Immediate Correction A supportive pipe clamp was installed to the unsupported armover and attached to the ceiling to provide support required to the sprinkler located in the milk cooler storage room on 9-29-15.</p> <p><b>Identification of Others Potentially Affected</b> The Director of Plant Services did a walk through with B &amp; R Fire Services and identified two additional unsupported armovers, and immediately installed hangers to add the support required by code. <b>Measures &amp;/or Systemic Changes</b> Education (Document #1) was provided to the Director of Plant Services to observe for and ensure correct installation of any newly added pipe to the existing sprinkler system moving forward.</p> <p><b>Monitoring/Quality Assurance</b> A Q.A. tool titled "Sprinkler installation checklist" (Document #5) will be completed by the Director of Plant Services or designee. The checklist will be</p> | 10/01/2015           |

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| K 0062<br>SS=D<br>Bldg. 01                       | <p>room in the kitchen was an unsupported armover to a sprinkler. Based on interview at the time of observation, the Director of Plant Services acknowledged the aforementioned sprinkler location was an unsupported armover greater than 24 inches in length for a steel pipe.</p> <p>3.1-19(b)<br/>3.1-19(ff)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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>Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. LSC 9.7.1 states all automatic sprinkler systems shall be maintained in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 states sprinkler piping or hangers shall not be used to support nonsystem components. This deficient</p> | K 0062  | <p>completed immediately following any installation of additional armover pipe and sprinklers, and will indicate the length of the pipe and whether or not it requires additional support and if so, that the support was added at time of install. This checklist will be submitted to the PI committee to assess compliance after each install. This will be an ongoing system with no stop date.</p> <p>Immediate Correction The identified cables were unattached/ removed from the sprinkler pipes on 9/29/15.<br/><b>Identification of Others Potentially Affected</b> The Director of Plant Services did a walk through with B &amp; R Fire Services and any additional wires/cables noted to be attached to the sprinkler pipes were removed. <b>Measures &amp;/or Systemic Changes</b> Education (Document #1) was provided to</p> | 10/01/2015   |  |   |  |

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|  | <p>practice could affect three staff and visitors in the south basement.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Director of Plant Services during a tour of the facility from 11:30 a.m. to 1:15 p.m. on 09/23/15, the following was noted in the south basement:</p> <p>a. a data cable was run through three sprinkler system adjustable swivel ring and all thread rod hanger assemblies for a twenty foot section of six inch in diameter sprinkler pipe.</p> <p>b. five cables were affixed to an adjustable swivel ring and all thread rod hanger assembly for a six inch in diameter sprinkler pipe.</p> <p>Based on interview at the time of the observations, the Director of Plant Services acknowledged sprinkler system piping and hangers in the south basement were being used to support nonsystem components.</p> <p>3.1-19(b)</p> |   | <p>the DOPS regarding not allowing the sprinkler system pipe to be used to support and/or hang cable and/or wiring from.</p> <p><b>Monitoring/Quality Assurance</b><br/>DOPS or designee will perform a visual assessment to check for noncompliance after any work is completed in the facility by outside contractors and will resolve any issue if noted. Any noncompliance will be reported to the P.I. committee as an ongoing system with no stop date.</p> |                      |   |

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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   |  |   |  |
| K 0071<br>SS=E<br>Bldg. 01                       | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Rubbish Chutes, Incinerators and Laundry Chutes:</p> <p>(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5.</p> <p>(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7.</p> <p>(3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4.</p> <p>(4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 laundry chutes were provided with a fire door assembly having a fire protection rating of one hour. LSC 8.4.1.3 states doors in barriers required to have a fire resistance rating shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect 14 residents, staff and visitors in the vicinity of the laundry chute by the nurses station.</p> | K 0071  | Immediate Correction Facility has contacted two door suppliers to order &/ or manufacture and have installed the 1 hour fire rated self-closing door to replace the identified laundry chute door identified. It will take more than 30 days for the door to be available and installed, but should not exceed 90 days. We respectfully request an extension of time to not exceed a completion date of December 15, 2015 for the installation of the 1 hour fire rated self-closing laundry | 12/15/2015   |  |   |  |

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|  | <p>Findings include:</p> <p>Based on observation with the Executive Director and the Director of Plant Services during a tour of the facility from 11:30 a.m. to 1:15 p.m. on 09/23/15, the first floor laundry chute door in the corridor by the nurses station was not provided with a labeled fire rated door and was not provided with a self closing device to self close and latch the door into the chute door frame. The chute door was provided with a locking mechanism which could be opened by the use of a key but would not latch into the door frame without locking the door. Based on interview at the time of observation, the Executive Director and the Director of Plant Services acknowledged the laundry chute was not provided with a labeled one hour fire rated door and was not provided with a self closing device to self close and latch the door into the chute door frame.</p> <p>3.1-19(b)</p> |   | <p>chute l door. Steps taken to increase fire safety awareness during this timeframe are: Additional smoke detection has been installed directly above the existing laundry chute door on 9-30-15 to help abate any risk while awaiting the new door. The laundry chute itself is already fully sprinklered. There is a fire extinguisher located directly across to the hall; within two steps reach. <b>Identification of Others Potentially Affected</b> N/A: No other laundry chute exists in facility. <b>Measures &amp;/or Systemic Changes</b> N/A: No other laundry chute exists in facility. <b>Monitoring/ Quality Assurance</b> N/A: No other laundry chute exists in facility.</p> |                      |   |
| K 0130<br>SS=F<br>Bldg. 01                       | <p>NFPA 101<br/>MISCELLANEOUS<br/>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors</p>  | K 0130  | <p>Immediate Correction All existing battery operated smoke detectors were cleaned using compressed air on 9/30/15. <b>Identification of Others Potentially Affected</b></p>   | 10/01/2015           |   |

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|  | <p>installed in 29 of 29 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Smoke Detector Checks" with the Executive Director and the Director of Plant Services during record review from 9:30 a.m. to 11:30 a.m. on 09/23/15, documentation of an itemized list by location of monthly battery operated smoke detector cleaning for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Director of Plant Services stated the aforementioned monthly battery operated smoke detector cleaning documentation only includes functional testing of the detectors and acknowledged documentation of an itemized list by location of monthly battery operated smoke detector cleaning for the most recent twelve month period was not available for review. Based on observations with the Executive Director and the Director of Plant Services during a tour of the facility from 11:30 a.m. to</p> |   | <p>N/A- no other battery smoke detectors are utilized. <b>Measures &amp; / or Systemic Changes</b> The facility has implemented monthly cleaning of the battery operated smoke detectors. Monthly cleaning documentation has been added to the existing monthly smoke detector checklist already in use and the form has been renamed from <i>Battery Operated Smoke Detector Checks</i> to <i>Battery Operated Smoke Detector Checks and Cleaning (Document #6)</i>. <b>Monitoring/ Quality Assurance</b> The Director of Plant Services or designee will present to each P.I. committee meeting the completed checklist for review to assess compliance with the system. This will be an ongoing Q.A. system with no planned stop date.</p> |                      |   |

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|  | <p>1:15 p.m. on 09/23/15, USI Electric Model 1122L battery operated smoke detectors are installed in each of 29 resident sleeping rooms in the facility. Manufacturer's instructions affixed to the back of the battery operated smoke detector in Resident Room 11 stated to clean the detector's sensor monthly. Based on interview at the time of the observations, the Director of Plant Services acknowledged monthly battery operated smoke detector cleaning documentation was not available for review.</p> <p>3.1-19(a)</p> |   |   |                      |   |