

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001090	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/13/2015
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NAME OF PROVIDER OR SUPPLIER ALLIED PHYSICIANS SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 53990 CARMICHAEL DR STE 100 SOUTH BEND, IN 46635
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 416.44(b).</p> <p>Survey Date: 11/13/15</p> <p>Facility Number: 010984 Provider Number: 15C0001090 AIM Number: 200268420A</p> <p>At this Life Safety Code survey, Allied Physicians Surgery Center, LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered except for the Data Room. The facility has a fire alarm system with smoke detection in the corridors.</p>	K 0000		
K 0021 Bldg. 01	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Any door with a required fire protection</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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	<p>rating, such as stairways, exit passageways, horizontal exits, smoke barriers, or hazardous area enclosures, if held open, is arranged to close automatically by the actuation of the manual fire alarm system and either smoke detectors arranged to detect smoke on either side of the opening or a complete automatic sprinkler system. 20.2.2.3, 21.2.2.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 fire door sets were arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect staff and up to 17 patients.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Contract Maintenance on 11/13/15 at 2:40 p.m., the fire doors near the Clean Workroom failed to close and latch when tested. Based on interview at the time of observation, the Executive Director and Contract Maintenance acknowledged the aforementioned condition and confirmed the set of doors were fire doors.</p>	K 0021	<p>Latch has been replaced by Maintenance Staff</p> <p>We are creating an inventory of all fire doors</p> <p>During our quarterly fire code red drills, all fire doors will be checked by staff for proper closure</p>	12/01/2015

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K 0029 Bldg. 01	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Hazardous areas separated from other parts of the building by fire barriers have at least one hour fire resistance rating or such areas are enclosed with partitions and doors and the area is provided with an automatic sprinkler system. High hazard areas are provided with both fire barriers and sprinkler systems 38.3.2, 39.3.2</p> <p>1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Soiled Linen Storage Room, a hazardous area, was provided with self closer and would latch into the frame. This deficient practice could affect staff and up to 10 patients in the PACU room.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Contract Maintenance on 11/13/15 at 1:05 p.m., three separate 45 gallon soiled linen and one 50 gallon trash containers were stored in the Soiled Linen room in PACU. When the door was released, it self closed, but failed to latch in the frame. Based on interview at the time of observation, the Executive Director and Contract Maintenance acknowledged the aforementioned condition.</p> <p>2. Based on observation and interview,</p>	K 0029	<p>1) Latch has been replaced by Maintenance Staff on 12/1/15 2) Self Closure device placed on door by Maintenance Staff on 11/20/15</p> <p>We are creating an inventory of all fire doors During our quarterly fire code red drills, all fire doors will be checked by staff for proper closure</p>	12/01/2015
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K 0048 Bldg. 01	<p>the facility failed to ensure the door to 1 of 1 Storage area in PACU, a hazardous area with combustible storage was equipped with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with Executive Director and Contract Maintenance on 11/13/15 at 1:09 p.m., seventeen large cardboard boxes and about one hundred small cardboard boxes were stored in the Storage room in PACU. When the door was tested, it failed to self close and latch into the frame. Based on interview at the time of observation, the Executive Director and Contract Maintenance acknowledged the aforementioned condition.</p> <p>416.44(b)(1) 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. 20.7.1.1, 21.7.1.1 Based on record review and interview, the facility failed to provide a 1 of 1 complete written policy for the protection of all occupants indicating procedures to be followed in the event the fire alarm</p>	K 0048	Fire Marshall Cherrone will be conducting Fire Watch training with the QA Coordinator and two maintenance personnel on 12/8/15 The revision to our policy and procedure titled "Code Red-Fire" will be finalized after	12/15/2015

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K 0050 Bldg. 01	<p>system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on interview and record review of the "Code Red - Fire" on 11/13/15 at 11:54 a.m., the Executive Director acknowledged the facility's documentation provided for a plan of action when the sprinkler system and fire alarm system was out of service for more than four hours in a twenty four hour period was not complete. The procedure did not include all elements required such as; the person conducting the fire watch shall have no other duties, the person conducting the fire watch shall be trained, and to include contacting the Indiana Department of Health.</p> <p>3.1-19(b)</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD 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. 20.7.1.2, 21.7.1.2 Based on record review and interview, the facility failed to ensure 7 of 7 fire</p>	K 0050	<p>completion of training; revised policy will be put into affect on 12/15/15 A Fire Watch Log will be submitted to Clay Township Fire Department upon completion of all Fire Watches</p> <p>QA Coordinator revised Emergency Drill Evaluation form on 11/30/15 to include proper</p>	11/30/2015			

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K 0051 Bldg. 01	<p>drills included the transmission of a fire alarm signal. LSC 21.7.1.2 requires fire frills in ambulatory health care facilities to include the transmission of the fire alarm signal. When drills are conducted between 9:00 p.m. and 6:00 a.m., a coded announcement shall be permitted to be used instead of audible alarms.</p> <p>Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. This deficient practice affects all occupants in the facility including staff, visitors and patients.</p> <p>Findings include:</p> <p>Based on record review of "Emergency Drill Evaluation" documentation with the Executive Director on 11/13/15 at 11:05 a.m., the fire drill documentation did not indicate a time for varification of trasmissison of the fire alarm signal. Based on interview at the time of observation, the Executive Director acknowledged the aforementioned condition.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD A manual fire alarm system, not a pre-signal type, is provided to automatically warn the building occupants. Fire alarm system has initiation notification and control function. The fire alarm system is arranged to automatically transmit an alarm to summon</p>		<p>documentation of time the monitoring company received the signal and name of employee who verified signal transmission</p> <p>Ongoing monitoring will continue to be done during all Emergency Fire Drills and tracked for compliance by QI Coordinator</p>	

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	<p>the fire department. 20.3.4.1, 21.3.4.1</p> <p>1. Based on record review, observation, and interview, the facility failed to ensure 2 of 2 fire alarm batteries were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-2.2 requires fire alarm systems to be tested according to Table 7.2.2. This deficient practice could affect all staff and occupants if the fire alarm panel backup battery power is unavailable.</p> <p>Findings include:</p> <p>Based on record review with the Executive Director and Contract Maintenance on 11/13/15 at 11:38 a.m., the Communication Company of South Bend "Fire Alarm and Life Safety System Inspection Certificate" noted two batteries were expired. Based on observation and interview, the Executive Director and Contract Maintenance acknowledged the batteries were dated 2010 and had not been replaced.</p> <p>2. Based on observation and interview, the facility failed to ensure smoke detectors connected to the fire alarm system in 2 of 2 smoke compartments were properly separated from the air handling system. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code.</p>	K 0051	<p>1) New batteries installed on 11/21/15 by FSA Mechanical Services Monitoring will be completed during yearly checks by Shambaugh & Son, LP 2) Shambaugh & Son, LP, coming on 12/12/15 to conduct functional & sensitivity testing and to evaluate which smoke detectors need to be moved; Due to surgery center work schedule and holiday all work to be completed by 1/9/16 Shambaugh & Son, LP will monitor NFPA codes for future changes and will make adjustments during yearly inspections</p>	01/09/2016

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	<p>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 could affect all staff and occupants.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and Contract Maintenance on 11/16/15 between 12:02 p.m. and 2:18 p.m., the following discovered smoke detectors were less than three feet from the air handling system:</p> <ul style="list-style-type: none"> a) Office #1 b) Office #2 c) Office Hallway d) Waiting room e) Business office f) Nourishment area g) #15 Pre-op room h) Clean linen room in pre-op i) Men's locker room from pre-op j) Woman's locker room from pre-op k) #14 Minor room 1 l) Office in PACU m) Electrical room in PACU n) Charge nurse office o) General storage p) Decontamination off of OR1 <p>Based on interview at the time of each observation, the Executive Director and Contract Maintenance acknowledged</p>			

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K 0066 Bldg. 01	<p>each aforementioned condition and provided measurements to confirm the smoke detectors were less than three feet away from the air handler system.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Smoking regulations are adopted, and include the posting of "NO SMOKING" signs or signs with the international symbol for no smoking in any room, ward, or compartment where flammable liquids, combustible gases or oxygen are used or stored, and in any other hazardous location. 20.7.4, 21.7.4 Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for staff and residents were maintained and the metal container with a self-closing cover was used for an ashtray. This deficient practice could affect at least 4 residents and facility staff who smoke cigarettes.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Contract Maintenance on 11/13/15 at 1:29 p.m., there were at least 40 cigarette butts on the ground in the designated resident smoke area. The smoking area was not provided with a "smokers oasis" which is a metal container with a long neck used for cigarette butts. Based on interview at the time of observation, the Executive</p>	K 0066	Area has been cleaned of cigarette butts and smoking receptacles have been ordered Receptacles have been received and monitoring will be completed daily by housekeeping and maintenance staff	12/07/2015

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K 0067 Bldg. 01	<p>Director and Contract Maintenance acknowledged the aforementioned condition.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Heating, ventilating, and air-conditioning comply with the manufacturer's specifications and section 9.2. 20.5.2.1, 21.5.2.1</p> <p>Based on record review, observation, and interview, the facility failed to ensure an undetermined number of dampers in the ductwork at smoke barriers and fire barriers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A to protect 88 of 88 residents. LSC 21.5.2.1 refers to Section 9.2. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all occupants, staff and visitors.</p> <p>Findings include:</p>	K 0067	Fire damper testing will be performed on 12/12/15 by Shambaugh & Son, LP Shambaugh & Son, LP will test every five years for compliance	12/12/2015

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K 0075 Bldg. 01	<p>Based on record review with Executive Director and Contract Maintenance on 11/13/15 at 3:38 p.m., the facility failed to provide any documentation of damper inspection during record review. Based on observation, air handlers with fire dampers were discovered in the smoke barrier in electrical room. Based on interview at the time of observation, the Executive Director and Contract Maintenance acknowledged the aforementioned condition.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Solid linen or trash collection receptacles shall not exceed 32 gallons (121L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft² (20.4L/m²). A capacity of 32 gal (121L) shall not be exceeded with any 64 ft² (5.9m²) area.</p> <p>Mobile soiled linen or trash collection receptacles with capacity greater than 32 gallons (121L) shall be located in a room protected as a hazardous area when not attended. 20.7.5.3, 21.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area which was not protected as a hazardous area for 5 of 5 areas used for Hazardous storage in the</p>	K 0075	Verified with Monarch Linen on 11/23/15 that current laundry bag capacity is 30 gallons; order placed with supply vendor on 12/2/15 to switch to trash bags with 30 gallon capacity Removed excess receptacles in Phase II on 12/2/15 to comply with 64 square foot area	12/12/2015

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K 0076 Bldg. 01	<p>corridor. This deficient practice could affects all staff and occupants.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Contract Maintenance on 11/13/15 between 12:46 p.m. and 2:02 p.m., the following was discovered:</p> <p>a) One 45 gallon soiled linen and one 45 gallon trash were next to each other in the Minor Room #1</p> <p>b) Three separate 45 gallon soiled linen and one 45 gallon trash in the Phase 2 Nurse's station</p> <p>c) Two separate 45 gallon soiled linen in the Back Nurse's station in Phase 2</p> <p>d) Two separate 45 gallon soiled linen by room #14 in Phase 2</p> <p>e) One 45 gallon soiled linen and one 50 gallon trash in Decontamination</p> <p>Based on an interview at the time of observation, the Executive Director and Contract Maintenance acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities, and NFPA 101.</p>				<p>40 gallon bags have been replaced on facility order sheet with 30 gallon bags</p> <p>Daily observation and monitoring will be completed by all staff members for compliance</p>		

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	<p>(a) Oxygen storage locations of greater than 3,000 cu. ft. are enclosed by a one hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu. ft. are vented to the outside.</p> <p>4.3.1.1.2, 20.3.2.4, 21.3.2.4</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 exterior oxygen supply storage locations was protected from the weather. NFPA 99, 4-3.5.2.2 requires cylinders stored in the open shall be protected against extremes of weather. During winter, cylinders stored in the open shall be protected from an accumulation of ice or snow. In summer, cylinders stored in the open shall be screened against continuous exposure to direct rays of the sun in those localities where extreme temperatures prevail. This deficient practice could affect the staff who have a key to get into the gated enclosure.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Contract Maintenance on 11/13/15 at 1:47 p.m., a large oxygen tanks was located outside surrounded by a chain link fence. The enclosure did not have a top cover and was not protected from sun, snow, or rain. Based on interview at the time of observation, the</p>	K 0076	<p>1) We are disputing this finding We contacted our exterior oxygen owner and supplier, Linde, LLC. They state our facilities supply system is comprised of two bulk cryogenic storage tanks (a main and a reserve), which have different requirements than cylinders; per NFPA99, bulk cryogenic supply systems must be installed to the guidelines of NFPA55, Section 8-13-2-7-1, which states "stationary containers shall not be installed within enclosed courts" (SEE ATTACHED BLUEPRINTS) Reviewed standard which refers to portable containers not bulk Bulk storage is greater than 50 feet from brick (not wood) structure 2) Electrical outlet moved to proper height on 11/29/15 by Martell Electric Receptacle is permanent and stationary</p>	11/29/2015

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	<p>Executive Director and Contract Maintenance acknowledged the aforementioned condition.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical outlets in the oxygen storage room on the second floor was located at least five feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Contract Maintenance on 11/13/15 at 1:34 p.m., there was one electrical outlet on the wall in the oxygen storage room. The outlet measured 57.5 inches from the floor. Based on interview at the time of observation, the Executive Director and Contract Maintenance acknowledged the aforementioned condition and provided the measurements.</p>			

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K 0114 Bldg. 01	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Ambulatory health care occupancies are separated from other tenants and occupancies by fire barriers with at least a 1 hour fire resistance rating. Doors in such barriers are solid bonded core wood of 1¾ inches or equivalent and are equipped with a positive latch and closing device. Vision panels, if provided in fire barriers or doors, are fixed fire window assemblies in accordance with 8.2.3.2.2.</p> <p>Based on record review, observation, and interview, the facility failed to ensure doors in fire barriers were fire resistive rated. NFPA 80, Standard for Fire Doors and Windows requires a door in a 2 hour firewall to have a fire resistive rating of 1 1/2 hours. This deficient practice could affect staff and up to 17 patients.</p> <p>Findings include:</p> <p>Based on record review with the Executive Director and Contract Maintenance on 11/13/15 between 9:56 a.m. and 12:04 p.m., during review of the facility's site plans all the fire and smoke barriers were discovered. One of the 2 hour fire-rated fire walls that traveled from exterior wall to exterior wall crossing between the Lobby and the Pre-op room. Based on observation, there is a bathroom door that is a part of the fire wall. No fire resistive rating could be found on the door. Based on interview</p>	K 0114	At time of the survey, surveyor reviewed blueprints A2,3, issue for "construction 4/19/99"; Blueprint revised and record drawing from 3/2000 should have been reviewed as it was the "completed facility" drawing On "completed" drawing it reflects the change in the firewall location so door is not part of firewall	11/13/2015

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K 0115 Bldg. 01	<p>during observation, the Executive Director and Contract Maintenance acknowledged the location of the fire wall, the lack of a fire resistive tag on the door, and the aforementioned condition.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Ambulatory health care facilities are divided into at least two smoke compartments with smoke barriers having at least 1 hour fire resistance rating. Doors in smoke barriers are equipped with positive latcher. Doors are constructed of not less than 1¾ inch thick solid bonded core wood or equivalent. Vision panels are provided and are of fixed wire glass limited to 1,296 sq. inch per panel. 20.3.7.1, 20.3.7.2, 20.3.7.3, 21.3.7.1, 21.3.7.2, 21.3.7.3</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 1 smoke barrier wall and 1 of 1 ceiling barrier was 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</p>	K 0115	<p>Gibson Lewis LLC will be fire caulking all penetration points in the firewall throughout the facility beginning on 12/12/15 and will complete by 12/19/15</p> <p>Any changes and/or additions that might create a penetration point in the fire wall will be done by qualified contractor with knowledge of fire wall construction</p>	12/19/2015

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K 0130 Bldg. 01	<p>designed for the specific purpose. This deficient practice could affect staff and up to 24 residents.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and Contract Maintenance on 11/13/15 between 1:31 p.m. to 2:59 p.m. the following smoke barrier and ceiling barrier penetrations were discovered:</p> <p>a) ceiling penetration measuring five inches by a quarter inch around copper pipe in the Med Gas Storage Room b) one inch smoke barrier penetration above the drop ceiling near OR7 c) four smoke barrier penetrations ranging from one quarter inch to one inch above the drop ceiling and a half inch penetration around conduit near OR1</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review and interview, the facility failed to ensure 3 of 3 facility's water heaters had a current inspection certificate to ensure the water heater was in safe operating condition. NFPA 101, in 21.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of</p>	K 0130	<p>1) Hartford Steam Boiler will complete inspection on 12/29/15 Due to difficulty in getting boiler inspection process will be started two months prior to expiration and added to PM check list 2) Shambauh & Sons, LP conducted 5 year sprinkler inspection on 12/3/15 Shambaugh & Son, LP will test every five years for compliance Dispute: 3) a) Gibson Lewis LLC will be fire</p>	12/29/2015

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	<p>residents. This deficient practice could affect all staff and occupants.</p> <p>Findings include:</p> <p>Based on record review and interview on 11/13/15 at 1:36 p.m., the Executive Director and Contract Maintenance acknowledged the water heater had three Certificate of Inspection that expired on 09/29/15.</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects all occupants in the facility including staff and visitors.</p> <p>Findings include:</p>		<p>caulking all penetration points in the firewall throughout the facility beginning on 12/12/15 and will complete by 12/19/15 b) At time of the survey, surveyor reviewed blueprints A2,3, issue for "construction 4/19/99"; Blueprint revised and record drawing from 3/2000 should have been reviewed as it was the "completed facility" drawing; this drawing reflects actual location of firewall. (SEE ATTACHED BLUE PRINTS) Request reinspection with proper blueprints No changes made since building construction 4) Shambaugh & Sons, LP installed 3 new sprinkler heads on 12/3/15 Monitoring will be conducted with yearly inspections</p>	

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	<p>Based on record review with Executive Director and Contract Maintenance on 11/13/15 at 3:32 p.m., none of the quarterly sprinkler system inspection and testing records indicated an internal inspection of the sprinkler system pipes had been conducted. Based on interview at the time of record review, the Executive Director and Contract Maintenance acknowledged the aforementioned condition and was unable to provide documentation.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 21.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is</p>			

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	<p>capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect staff and up to 24 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Executive Director and Contract Maintenance on 11/13/15 between 1:25 p.m. and 3:16 p.m., the following fire wall penetrations were discovered:</p> <p>a) three separate penetrations ranging from one quarter inch to three quarter inch penetrations in the Electrical room</p> <p>b) the firewall in Pre-ops stops two feet from the ceiling. Also, a one inch by one and a half inch penetration</p> <p>Based on interview at the time of each</p>			

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	<p>observation, the Executive Director and Contract Maintenance acknowledged each aforementioned condition.</p> <p>4. Based on observation and interview, the facility failed to replace 3 of 6 painted sprinkler heads in the Mechanical Room and 1 of 1 sprinkler head in the Autoclave room. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected 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 staff only.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Contract Maintenance on 11/13/15 at 1:39 p.m. then again at 2:13 p.m., three sprinkler heads in the Mechanical Room were corroded. Then again one sprinkler head was corroded in the Back of the Autoclave room. Based on interview at the time of each observation, the Executive Director and Contract Maintenance acknowledged each aforementioned condition.</p>			

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K 0147 Bldg. 01	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Electrical wiring and equipment are in accordance with NFPA 70, National Electrical Code 9.1.2, 20.5.1</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 Nourishment Area, 2 of 3 Waiting Room bathrooms, and 1 of 2 Bathrooms in Pre-Op was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, 517-20 requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and at least one person per bathroom and 6 occupants near the Nourishment Area.</p> <p>Findings include:</p> <p>Based on an observation with the Executive Director and Contract Maintenance on 11/13/15 between 12:24 p.m. and 12:37 p.m., the Nourishment Area, Waiting Room bathrooms, and Pre-Ops bathroom had an electrical receptacle on the wall within three feet of a sink that was provided with GFCI protection to prevent electric shock. Each outlet was tested and failed to trip. Based</p>	K 0147	<p>1) GFCI's replaced on 11/14/15 by FSA Mechanical Services; GFCI monthly testing added to PM schedule effective 12/15 2) IT Director removed surge protectors connected to each other on 12/3/15 IT & maintenance personnel have been educated on NFPA 70 Electrical code; any future electrical changes will be performed by qualified electrical contractor for compliance with code 3) Junction box cover installed on 11/21/15 by FSA Mechanical Services Any future electrical change will be performed by qualified electrical contractor for compliance with code</p>	12/03/2015

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	<p>on an interview at the time of each observation, the Executive Director and Contract Maintenance acknowledged each aforementioned condition.</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observation with Executive Director and Contract Maintenance on 11/13/15 at 12:29 p.m., a surge protector was powering another surge protector in the Data Room. Based on interview at the time of observation, the Executive Director and Contract Maintenance acknowledged the aforementioned condition.</p> <p>3. Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes above the drop ceiling near Minor 2 was maintained in a safe operating condition. LSC 19.5.1 requires utilities</p>			

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K 0211 Bldg. 01	<p>comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect staff.</p> <p>Findings include:</p> <p>Based on observation with Executive Director and Contract Maintenance on 11/13/15 at 2:45 p.m., a junction box was discovered with exposed wiring above the drop ceiling near the Minor 2 room. Based on interview at the time of observation, the Executive Director and Contract Maintenance acknowledged the aforementioned condition.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD</p> <ul style="list-style-type: none"> o Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor, 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 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 			

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	<p>sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 alcohol based hand sanitizers in the Minor 1 room was not installed over an ignition source. NFPA 101, in 19.1.1.3 requires all health facilities to be designed, constructed, 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 one patient in the Minor 1 room.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Contract Maintenance on 11/13/15 at 12:49 p.m., an alcohol based hand sanitizer was located approximately 6 inches above the light switch in the Minor 1 room. Based on interview at the time of observation, the Executive Director and Contract Maintenance acknowledged the aforementioned condition.</p>	K 0211	Maintenance personnel moved hand sanitizer to appropriate area away from electrical area Any new or additional hand sanitizer units location will be installed per standard	11/20/2015