

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/11/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Dates: 07/10/13 and 07/11/13</p> <p>Facility Number: 000622 Provider Number: 15G079 AIM Number: 100272170</p> <p>Surveyors: Dennis Austill, Life Safety Code Supervisor, Keith Briner, Medical Surveyor/Life Safety Code Specialist Trainee, Tim Shebel, LSW, Medical Surveyor/Life Safety Code Specialist Trainee</p> <p>At this Life Safety Code survey, Golden Living Center-North Willow 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 three story facility with a basement was determined to be of Type II (111) construction and fully sprinklered. The</p>	K010000		
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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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	<p>facility has a fire alarm system with smoke detection on all levels in the corridors and all areas not separated from the corridor. The facility has battery operated smoke detectors in all resident rooms. The facility has a capacity of 208 and had a census of 146 at the time of this visit.</p> <p>All areas where clients have customary access were sprinklered. The facility has two detached wooden sheds providing facility services which were not sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 07/17/13.</p>				

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K010015	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to provide documentation for the flame spread rating of interior finish materials installed within 2 of 200 rooms within the facility. This deficient practice would affect only staff.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) There was wood paneling on the walls of the 3rd floor social worker office used as an interior finish.</p> <p>b) There was wood paneling on the walls of the 3rd floor Qualified Mental Retardation Professional (QMRP) office. Based on interview with the Maintenance Supervisor at the time of observation, documentation was not available to demonstrate the paneling was provided</p>	K010015	<p>K015 I Third floor Social Worker office and Program Director office have been painted with paint containing fire retardant, the specifications for that fire retardant are on file in the maintenance office.</p> <p>II This deficiency could affect staff.</p> <p>III Maintenance Director has checked other areas of the building to see if they contain paneling areas in need of flame retardant treatment. A plan is in place to address areas discovered.</p> <p>IV All materials used to repair or replace building construction will use proper flame retardant materials. Maintenance Director will keep the specifications on file for those products. Completed by 8-10-13.</p>	08/10/2013			

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	with a flame spread rating of Class A, B or C or had been treated with flame retardant material. 3.1-19(b)			

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K010018	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>1) Based on observation and interview, the facility failed to ensure 11 of 200 corridor doors were capable of positive latching. This deficient practice could affect all clients as well as staff or visitors throughout the facility.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. and on 7/11/13 from 8:45 a.m. to 11:30 a.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) The basement women's locker room corridor door hit the frame and did not latch.</p> <p>b) The beauty shop corridor door hit the the frame and did not latch.</p>	K010018	<p>K018</p> <p>I The doors sited during the observation now latch to the frame. The doors are not propped that were propped on the date of observation.</p> <p>II This deficiency could affect all residents, staff and visitors to the building.</p> <p>III The Maintenance Director has checked the other doors in the building for issues of latching and has a plan to address the issues noted. Staff have been re-educated that doors may not be propped. Corridor doors have been checked for holes and repaired if needed.</p> <p>IV Maintenance Director will check the doors will to assure they latch and that doors are not</p>	08/10/2013
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	<p>c) The basement janitor's closet lacked a door knob and did not latch.</p> <p>d) The corridor door for room 300 did not latch into the frame.</p> <p>e) The corridor door for the 3rd floor West hall program room did not latch into the frame.</p> <p>f) The corridor door for the 3rd floor South hall program room did not latch into the frame.</p> <p>g) The 2nd floor recreation storage room corridor door lacked a positive latching mechanism and did not latch into the frame.</p> <p>h) The 3rd floor cleaning room corridor door was missing the door latch and did not latch into the frame.</p> <p>i) The corridor door for room 226 did not latch into the frame.</p> <p>j) The corridor door for the 2nd floor clean linen room between room 208 and room 210 did not latch into the frame.</p> <p>k) The corridor door for room 106 did not latch into the frame.</p> <p>Based on interview during the times of observation, the Maintenance Supervisor acknowledged the aforementioned doors did not latch into the frames.</p> <p>3.1-19(b)</p> <p>2) Based on observation and interview, the facility failed to ensure doors protecting corridor openings did not have</p>		<p>propped and that corridor doors are free of holes weekly for 3 weeks and then monthly thereafter. Completed by 8-10-13.</p>				

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	<p>an impediment to the closing of the doors in 2 of 200 doors. This deficient practice could affect 2-4 clients using the beauty shop or staff.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) The basement employee break room door was held open by a trash container.</p> <p>b) The beauty shop corridor door was held open by a wedge under the door.</p> <p>Based on interview during the times of observation, the Maintenance Supervisor acknowledged the aforementioned doors were blocked open.</p> <p>3.1-19(b)</p> <p>3) Based on observation and interview, the facility failed to ensure 4 of 200 room corridor doors would resist the passage of smoke. This deficient practice could affect 20 clients and staff throughout the facility.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. and on 7/11/13 from 8:45 a.m.</p>				

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	<p>to 11:30 a.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) The 3rd floor clean linen room door had four holes at the top of the door.</p> <p>b) The 2nd floor janitor's closet had 2 holes through the door above and below the door knob.</p> <p>c) There was a 3/4 inch gap at the top of the door of room 128</p> <p>d) There was a 3/4 inch gap at the top of the door of room 126.</p> <p>Based on interview during the times of observation, the Maintenance Supervisor acknowledged the aforementioned doors were not smoke resistive.</p> <p>3.1-19(b)</p>			

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K010020	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 ensure 2 of 3 vertical openings were protected with a one hour fire resistance rating. LSC Section 8.2.5.2 requires openings through floors, such as stairways, to be enclosed with fire barrier walls. The passage of building service materials shall be protected so that the space between the penetrating item and the fire barrier shall be filled with a material capable of maintaining the fire resistance of the fire barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect approximately 48 of 146 clients, staff and/or visitors using the stairwells if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. and on 7/11/13 from 8:45 a.m. to 11:30 a.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) The 3rd floor West stairwell above the</p>	K010020	<p>K020 I Missing drywall sited has been patched with 5/8" drywall.</p> <p>II This deficiency would affect 48 of 148 residents, staff and visitors to the building.</p> <p>III Maintenance Director has checked fire barrier walls in the building for further issues of this type and repaired them.</p> <p>IV Maintenance completes environmental rounds to assure drywall is intact weekly for three weeks and then monthly thereafter. Issues noted are placed on building engines for scheduled repair. Completed by 8-10-13.</p>	08/10/2013			

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	<p>ceiling tile on the corridor side of the stairwell door had a four inch by four inch section of missing double layer 5/8 inch drywall that would not provide a one hour fire resistance.</p> <p>b) The 2nd floor West stairwell above the ceiling tile on the corridor side of the stairwell door had a four inch by four inch section of missing double layer 5/8 inch drywall that would not provide a one hour fire resistance.</p> <p>c) The 1st floor West stairwell above the ceiling tile on the corridor side of the stairwell door had a four inch by four inch section of missing double layer 5/8 inch drywall that would not provide a one hour fire resistance.</p> <p>d) The 1st floor South West stairwell above the ceiling tile on the corridor side of the stairwell door had two sections, a four inch by four inch section and a two inch by two inch section of missing double layer 5/8 inch drywall that would not provide a one hour fire resistance.</p> <p>Based on interview during the times of observation, the Maintenance Supervisor acknowledged the aforementioned stairwell walls did not provide a fire resistance rating of one hour.</p> <p>3.1-19(b)</p>						

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K010021	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 doors serving hazardous areas such as a generator room was held open only by a device arranged to automatically close the door upon activation of the fire alarm system. This deficient practice could affect only staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. with the Maintenance Supervisor, the generator/maintenance office/storage room door was held open by a device, an electric motor against the door, which would not allow the door to close automatically upon activation of the fire alarm system. Based on interview at</p>	K010021	<p>K021 I Maintenance door is no longer propped open.</p> <p>II This deficiency may affect staff and visitors.</p> <p>III Staff have been re-educated that doors may not be propped</p> <p>IV Maintenance completes environmental rounds to assure doors are not propped weekly for three weeks and then monthly thereafter. Any issues are corrected immediately. Completed by 8-10-13.</p>	08/10/2013			

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	<p>the time of observation, the Maintenance Supervisor acknowledged the door was blocked open with the electric motor and would not automatically close upon activation of the fire alarm system.</p> <p>3.1-19(b)</p>			

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K010022	<p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 2 of 8 paths of egress were marked with readily visible exit signs to make the direction of travel to reach the nearest exit apparent. LSC 7.10.1.2 requires exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. This deficient practice affects clients, staff and visitors on the 1st and 3rd floors.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) The exit sign on the south side of the 3rd floor South hall set of smoke barrier doors was facing the wrong direction and would not indicate the direction of exit travel through the set of smoke barrier doors.</p> <p>b) Decorations hanging from the ceiling on the 1st floor in the main lobby were obstructing the view of the exit signs. Based on interview during the times of</p>	K010022	<p>K022 I The exit sign on 3rd floor has been correctly placed. There are no decorations obstructing the view of the exit sign on 1st floor.</p> <p>II This deficiency could affect residents, staff and visitors on 1st and 3rd floors.</p> <p>III Maintenance Director has checked the building for proper positioning of exit signs and that no decorations block exit signs.</p> <p>IV Maintenance completes rounds weekly for three weeks and then monthly thereafter checking for any issues with exit signs. Environmental rounds shows no decorations obstruct view of exit signs. Completed by 8-10-13.</p>	08/10/2013			

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	<p>observation, the Maintenance Supervisor acknowledged the exit signs were not readily visible.</p> <p>3.1-19(b)</p>			

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K010025	<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 smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that 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 could affect all clients as well as staff and visitors if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. and on 7/11/13 from 8:45 a.m.</p>	K010025	<p>K025 I Holes in smoke barriers are repaired around conduit and expanding foam issue resolved in walk-in freezer. II This deficiency could affect all residents, staff and visitors. III Conduits in other areas of smoke barriers have been checked by maintenance to assure they are properly sealed and to assure no improper foam was used with any issues noted addressed. IV Maintenance completes rounds weekly for three weeks and then monthly thereafter checking for any issues with holes in conduit or presence of expanding foam or inappropriate material utilized. Completed by 8-10-13.</p>	08/10/2013			

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	<p>to 11:30 a.m. with the Maintenance Supervisor, there were exposed penetrations through the smoke barriers above the ceiling tiles at the following locations that were not firestopped:</p> <p>a) The 3rd floor south dining room smoke barrier had a three inch annular space around a conduit penetration that was not sealed.</p> <p>b) The 3rd floor south hall smoke barrier had a three inch annular space around a conduit penetration that was not sealed.</p> <p>c) The 2nd floor north hall smoke barrier had two penetrations with a two inch annular space around wires that were not sealed.</p> <p>d) The 2nd floor south hall smoke barrier had a penetration with a two inch annular space around a red wire that was not sealed.</p> <p>e) The 1st floor south hall smoke barrier had two penetrations with a three inch annular space around a water line and a one inch annular space around wiring that were not sealed.</p> <p>Additionally, there was expanding foam used to fill in the gap around the base of a sprinkler head in the walk-in freezer and there was a four inch diameter hole in the ceiling tile next to the 3rd floor south dining room smoke barrier door.</p> <p>Based on interview during the times of observation, the Maintenance Supervisor acknowledged the unprotected openings</p>						

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	through the smoke barriers. 3.1-19(b)			

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K010027	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 2 of 11 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect at least 48 of 146 clients as well as staff and visitors.</p> <p>Finding include: Based on observation on 7/11/13 during the observation tour from 8:45 a.m. to 11:30 a.m. with the Maintenance Supervisor, the following was noted: a) The coordinating device on the 2nd floor south dining room smoke barrier doors did not operate properly preventing</p>	K010027	<p>K027 I Coordinator has been repaired/replaced, hole in door repaired. II This deficiency could affect 48 out of 148 residents, staff and visitors. III Maintenance has checked doors with coordinators to assure they function properly and that there are no holes present in them. IV Maintenance completes rounds weekly for three weeks and then monthly thereafter checking for any issues with doors with coordinators functioning properly and no holes are present in them. Completed by 8-10-13.</p>	08/10/2013			

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	<p>the doors from closing completely leaving a three inch gap.</p> <p>b) The 2nd floor south hall smoke barrier doors had a pencil size hole near the top and through the east door of the set of doors. Based on interview during the time of observations, the Maintenance Supervisor acknowledged the spring was broken on the coordinator and the hole through the smoke barrier door.</p> <p>3.1-19(b)</p>			

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K010029	<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 4 of 10 doors serving hazardous areas closed and latched to prevent the passage of smoke. This deficient practice would not affect clients but could affect staff in the basement.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) The kitchen storage room exceeded 50 square feet and the door was not provided with a door closer. The room was used for the storage of combustible boxes. Based on interview during the time of observation, the Maintenance Supervisor acknowledged the door to this room lacked a door closer and would need to be</p>	K010029	<p>K029</p> <p>I The clean laundry room door has been repaired so there are no holes, The central supply door closes and the two supply areas without automatic closers now have door closers on them.</p> <p>II This deficiency could affect basement staff.</p> <p>III Storage areas have been checked to assure they contain closers if needed, doors have been checked for holes. Repairs have been made on those issues noted.</p> <p>IV Maintenance completes rounds weekly for three weeks and then monthly thereafter checking for any issues with storage areas having closers on them and checking for holes in doors. Completed by 8-10-13.</p>	08/10/2013			

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	<p>manually pulled shut to latch the door.</p> <p>b) The clean laundry room door had two holes in the door below the door handle. Based on interview during the time of observation, the Maintenance Supervisor acknowledged the holes through the door below the handle would not resist the passage of smoke.</p> <p>c) The recreation storage room exceeded 50 square feet and the door was not provided with a door closer. The room was used for the storage of combustible boxes. Based on interview during the time of observation, the Maintenance Supervisor acknowledged the door to this room lacked a door closer and would need to be manually pulled shut to latch the door.</p> <p>d) The central supply storage room exceeded 50 square feet and the door was provided with a door closer but the door hit the frame and did not self close and latch. The room was used for the storage of combustible boxes. Based on interview during the time of observation, the Maintenance Supervisor acknowledged the door to this room even with a door closer, the door would need to be manually pulled shut to latch the door.</p> <p>3.1-19(b)</p>			

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K010033	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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. 8.2.5.2, 19.3.1.1</p> <p>1) Based on observation and interview, the facility failed to ensure 2 of 3 vertical openings were protected with a one hour fire resistance rating. LSC Section 8.2.5.2 requires openings through floors, such as stairways, to be enclosed with fire barrier walls. The passage of building service materials shall be protected so that the space between the penetrating item and the fire barrier shall be filled with a material capable of maintaining the fire resistance of the fire barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect approximately 48 of 146 clients, staff and/or visitors using the stairwells if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. and on 7/11/13 from 8:45 a.m. to 11:30 a.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) The 3rd floor West stairwell above the</p>	K010033	<p>K033</p> <p>I First floor north stairwell door now is latched so it hits the frame, missing drywall has been repaired, and south stairwell doors on first and second floor are contracted to have an appropriate mechanism so that it latches easily like the one present on third floor south.</p> <p>II This deficient practice could affect residents, staff and visitors.</p> <p>III Maintenance has observed other fire doors and areas surrounding them to assure drywall is intact and doors latch to frame and doors latch easily upon opening. Repairs have been made on those issues noted or contract work schedule for completion.</p> <p>IV Maintenance completes environmental rounds to assure drywall is intact, fire doors latch to frame and south stairwell doors latch easily after opening weekly for three weeks and then monthly thereafter. Issues noted are placed on building engines for scheduled repair. Completed by</p>	08/10/2013			

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	<p>ceiling tile on the corridor side of the stairwell door had a four inch by four inch section of missing double layer 5/8 inch drywall that would not provide a one hour fire resistance.</p> <p>b) The 2nd floor West stairwell above the ceiling tile on the corridor side of the stairwell door had a four inch by four inch section of missing double layer 5/8 inch drywall that would not provide a one hour fire resistance.</p> <p>c) The 1st floor West stairwell above the ceiling tile on the corridor side of the stairwell door had a four inch by four inch section of missing double layer 5/8 inch drywall that would not provide a one hour fire resistance.</p> <p>d) The 1st floor South West stairwell above the ceiling tile on the corridor side of the stairwell door had a two sections, a four inch by four inch section and a two inch by two inch section of missing double layer 5/8 inch drywall that would not provide a one hour fire resistance.</p> <p>Based on interview during the times of observation, the Maintenance Supervisor acknowledged the aforementioned stairwell walls did not provide a fire resistance rating of one hour.</p> <p>3.1-19(b)</p> <p>2) Based on observation and interview the facility failed to maintain the vertical</p>		8-10-13.				

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	<p>opening protection of 2 of 3 exit stairs. LSC 8.2.5.2 requires enclosure of vertical openings including stairwells with fire barrier walls. NFPA 80, Standard for Fire Doors and Windows, 1999 Edition, 2-1.4.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficient practice could affect any resident using the 1st floor A wing stairwell.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. and on 7/11/13 from 8:45 a.m. to 11:30 a.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) The 1st floor north stairwell door was not latched the door hit the frame.</p> <p>b) The 1st and 2nd floor south stairwell doors were equipped with a device that used a dead bolt which had to be manually activated to latch the door.</p> <p>Based on interview at the time of observations, the Maintenance Supervisor acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p>						

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K010038	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1) Based on observation and interview, the facility failed to ensure exit egress for 1 of 8 exits was arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires that means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires that walking surfaces in the means of egress shall comply with 7.1.6.2 through 7.1.6.4. LSC Section 7.1.6.2 requires abrupt changes in elevation shall not exceed 1/4 inch. LSC Section 7.1.6.3 requires walking surfaces to be nominally level. LSC Section 7.1.6.4 requires walking surfaces to be slip resistant under foreseeable conditions. This deficient practice could affect any client, staff or visitors using the north stairwell exit.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. with the Maintenance Supervisor, the concrete/asphalt surface at the end of the north stairwell exit sidewalk was deteriorated with loose gravel and cracks ranging from half an inch to one inch in width with a depth of</p>	K010038	<p>K038</p> <p>I For the north fire exit ramp a Capital Expense Request has been approved to repair or replace it, and the north entrance has a designated manual release as per our alarm system company recommendations.</p> <p>II This deficient practice may affect all residents, staff and visitors to the building.</p> <p>III Maintenance completes environmental rounds to assure ramps are in good repair (the north ramp has a Capital Expense Request approved) and any necessary manual release devices are designated and or present on doors that require them.</p> <p>IV Maintenance has observed the building to assure ramps are in good repair (the north ramp has an approved Capital Expense Request approved) has and doors that require it have a manual release device present weekly for three weeks and then monthly thereafter. Work to repair areas is in process if any located. Completed by 8-10-13.</p>	08/10/2013			

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	<p>1/2 inch.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned sidewalk was deteriorated with loose gravel.</p> <p>3.1-19(b)</p> <p>2) Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 Access-Controlled Egress doors was in accordance with LSC 7.2.1.6.2.</p> <p>LSC 7.2.1.6.2(c) Access-Controlled Egress Doors. Where permitted in Chapters 11 through 42, doors in the means of egress shall be permitted to be equipped with an approved entrance and egress access control system, provided that</p> <p>(a) A sensor is provided on the egress side arranged to detect an occupant approaching the doors and the doors are arranged to unlock upon detection of approaching occupant or loss of power to the sensor; and</p> <p>(b) Loss of power to that part of the access control system that locks the doors automatically unlocks the doors; and</p> <p>(c) The doors are arranged to unlock from a manual release device located 40 in. (102 cm) to 48 in. (122 cm) vertically above the floor and within 5 ft (1.5 m) of</p>			

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	<p>the secured doors. The manual release device shall be readily accessible and clearly identified by a sign that reads: "PUSH TO EXIT".</p> <p>When operated, the manual release device shall result in direct interruption of power to the lock - independent of the access control system electronics - and the doors shall remain unlocked for at least 30 sec; and</p> <p>(d) Activation of the building fire-protective signaling system, if provided, automatically unlocks the doors, and the doors remain unlocked until the fire-protective signaling system has been manually reset; and</p> <p>(e) Activation of the building automatic sprinkler or fire detection system, if provided, automatically unlocks the doors and the doors remain unlocked until the fire-protective signaling system has been manually reset.</p> <p>This deficient practice could affect any client, staff or visitors using the main entrance/exit door.</p> <p>Findings include:</p> <p>Based on observation on 07/11/13 during the observation tour from 8:45 a.m. to 11:30 a.m. with the Maintenance Supervisor, the main entrance/exit access controlled egress doors lacked a manual release device that would result in direct</p>						

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	<p>interruption of power to the lock. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned main entrance access controlled egress doors could be opened by the sensor or pressing the handicapped button on the wall next to the door.</p> <p>3.1-19(b)</p>			

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K010050	<p>NFPA 101 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>1) Based on interview and record review, the facility failed to conduct quarterly fire drills on each shift for 1 of 4 quarters. This deficient practice affects all occupants in the facility including staff, visitors and clients.</p> <p>Findings include:</p> <p>Based on review of "Report of Monthly Fire Drill" with the Maintenance Supervisor from 11:30 a.m. to 2:30 p.m. on 07/10/13, a fire drill was not documented for the first shift of the second quarter of 2013. Based on interview at the time of review, the Maintenance Supervisor acknowledged a first shift fire drill was conducted early this month to make up for June, 2013, but there was no other documentation</p>	K010050	<p>K050</p> <p>I A personnel counseling has been completed with the Maintenance Director that states there will be no missing fire drills.</p> <p>II This deficient practice may affect residents, staff and visitors.</p> <p>III A fire drill schedule is in place and the Maintenance Director instructed to follow the schedule as written.</p> <p>IV Fire drill schedule is approved by ED/Designee. Maintenance Director gives copy of each drill to ED/Designee to assure compliance. Completed by 8-10-13</p>	08/10/2013			

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	<p>available for review to verify these drills were conducted.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2) Based on record review and interview, the facility failed to insure fire drills included the transmission of a fire alarm signal in 5 of 5 fire drills conducted between 6:00 a.m. and 9:00 p.m. LSC 19.7.1.2 requires that fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice affects all occupants in the facility including staff, visitors and clients.</p> <p>Findings include:</p> <p>Based on review of "Report of Monthly Fire Drill" with the Maintenance Supervisor from 11:30 a.m. to 2:30 p.m.</p>				

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	<p>on 07/10/13, the documentation for the drills performed between the hours of 6:00 a.m. and 9:00 p.m. on 12/15/12, 7:45 a.m.; 10/30/12, 4:30 p.m.; 09/25/12, 10:30 a.m.; 07/29/12, 4:30 p.m.; and 03/09/13, 7:00 a.m. did not indicate the fire alarm system had been activated. Based on interview, the Maintenance Supervisor acknowledged the fire alarm monitoring company is contacted before and after the fire drill but was not documented on the fire drill form.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>3) Based on record review and interview, the facility failed to conduct fire drills at unexpected times in 9 of 11 fire drills. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include: Based on review of "Report of Monthly Fire Drill" with the Maintenance Supervisor from 11:30 a.m. to 2:30 p.m. on 07/10/13, the following was noted: a) Two of three first shift fire drills were conducted between 7:00 a.m. and 7:45</p>			

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	<p>a.m.</p> <p>b) Two of four second shift fire drills were conducted between 9:00 p.m. and 9:15 p.m. and two of four second shift fire drills were conducted at 4:30 p.m.</p> <p>c) Three of four third shift fire drills were conducted between 12:00 a.m. and 12:30 a.m.</p> <p>Based on interview at the time of review, the Maintenance Director acknowledged the fire drills were not held randomly.</p> <p>3.1-19(b) 3.1-51(c)</p>				

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K010051	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 3 of 73 smoke detectors connected to the fire alarm system were properly separated from an air supply or return vent. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. 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 at least 10 to 15 clients as well as staff and visitors.</p> <p>Findings include: Based on observation on 07/10/13 during</p>	K010051	<p>K051 I The 3 smoke detectors located too close to air vents have been moved to the appropriate distance from them.</p> <p>II This deficient practice could affect up to 15 residents, staff and visitors.</p> <p>III Maintenance has checked the building to assure smoke detectors present and that all smoke detectors are located the proper distance from air vents.</p> <p>IV Maintenance completes environmental rounds to assure that smoke detectors are located the proper distance from air vents</p>	08/10/2013			

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	<p>the observation tour from 2:30 p.m. to 5:30 p.m. and on 7/11/13 from 8:45 a.m. to 11:30 a.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) A corridor smoke detector located on the 1st floor south hall near room 127 was twelve inches from an air supply vent</p> <p>b) A corridor smoke detector located on the 1st floor west hall near room 109 was six inches from an air return vent.</p> <p>c) A smoke detector on the east side of the 2nd floor south dining room smoke barrier door was 12 inches from an air supply vent.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged the distances between the vents and agreed the air flow could interfere with smoke detector function.</p> <p>3.1-19(b)</p>		weekly for three weeks and then monthly thereafter. Completed by 8-10-13.				

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K010052	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 NFPA 70 and 72. 9.6.1.4</p> <p>1) Based on record review and interview, the facility failed to ensure the fire alarm system was tested to include the transmission of the fire alarm signal during 4 of 4 quarters. NFPA 72, National Fire Alarm Code, in Table 7-3.2, Testing Frequencies at number 29 requires quarterly testing of the off-premises transmission equipment. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on review of "Report of Monthly Fire Drill" with the Maintenance Supervisor from 11:30 a.m. to 2:30 p.m. on 07/10/13, the documentation for the drills performed between the hours of 6:00 a.m. and 9:00 p.m. on 12/15/12, 7:45 a.m.; 10/30/12, 4:30 p.m.; 09/25/12, 10:30 a.m.; 07/29/12, 4:30 p.m.; and 03/09/13, 7:00 a.m. did not indicate the fire alarm system had been activated. Based on interview, the Maintenance Supervisor acknowledged the fire alarm monitoring company is contacted before and after the</p>	K010052	<p>K052 I Maintenance Director has been instructed to contact the fire alarm monitoring company before and after the drill, which he has been, and to document information on the Fire Drill form including who he spoke with the time of the call and anything they told him. Annual device testing of fire alarm system equipment including location and serial numbers was completed and a copy is attached to this report. A copy was obtained from the fire alarm monitoring company.</p> <p>II This deficient practice could affect residents, staff and visitors of the building.</p> <p>III Maintenance Director has been trained to contact the fire alarm monitoring company before and after the drill, which he has been, and to document information on the Fire Drill form including who he spoke with the time of the call and anything they told him. Re-education has been completed with the Maintenance Director that he must have annual</p>	08/10/2013			

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	<p>fire drill but was not documented on the fire drill form.</p> <p>3.1-19(b)</p> <p>2) Based on record review and interview, the facility failed to ensure documentation for the annual testing of 1 of 1 fire alarm system's components and devices such as smoke detectors, heat sensors and fire alarm pull stations was complete. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors, heat sensors, fire alarm pull stations, and fire alarm control equipment be tested annually. The inspection should include locations and serial numbers, the test/inspection done and whether each device passed or failed. This deficient practice could affect all occupants of the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's "Inspection and Testing Form" for the fire alarm system dated 01/02/13 with the Maintenance Supervisor from 11:30 a.m. to 2:30 p.m. on 07/10/13, the comment section of the "Alarm-Initiating Device and Circuit Info" indicated "Visually and functionally checked all initiating devices except the heat which were visually inspected only. All passed inspection".</p>		<p>testing of fire alarm equipment including location and serial numbers and keep a copy in his file.</p> <p>IV Fire drill schedule is approved by ED/Designee. Maintenance Director gives copy of each drill to ED/Designee to assure compliance. This includes having documented call to the fire alarm monitoring company and documenting who he spoke with, time of call and anything they told him. Maintenance Director will provide a copy of the fire alarm company report that shows the devices are tested annually including their serial numbers and locations. Completed by 8-10-13.</p>				

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	<p>Based on interview at the time of review, the Maintenance Supervisor acknowledged the inspection form did not include specific locations, serial numbers or pass/fail results for individual initiating devices.</p> <p>3-1.19(b)</p>			

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K010056	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, 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 1 of 1 sprinkler systems was installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, NFPA 13, 3-1.1 states all materials and devices essential to successful system operation shall be listed. This deficient practice could affect 6 of 146 clients within the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. and on 7/11/13 from 8:45 a.m. to 11:30 a.m. with the Maintenance Supervisor, a pendant sprinkler with the fusible link removed and replaced with a</p>	K010056	<p>K056</p> <p>I The three sprinkler heads sited have been changed to appropriate ones.</p> <p>II This deficient practice could affect residents, visitors and staff.</p> <p>III Maintenance Director has check other sprinkler heads to assure they are appropriate ones.</p> <p>IV Maintenance completes environmental rounds to assure that sprinkler heads are appropriate weekly for three weeks and then monthly thereafter. Completed by 8-10-13.</p>	08/10/2013

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	<p>residential type sprinkler within the frame of the pendant sprinkler was noted in the small closet in rooms 108, 132 and 312. Based on interview during the times of observation, the Maintenance Supervisor did not know if the sprinklers were listed.</p> <p>3.1-19(b)</p>			

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K010062	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1) Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.1 requires that sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect any client, staff or visitor throughout the facility.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. and on 7/11/13 from 8:45 a.m. to 11:30 a.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) The sprinkler head located in the 2nd</p>	K010062	<p>K062</p> <p>I There are no decorations hanging near sprinkler heads. Sprinkler heads sited in part a-f have been replaced. Issues with sprinkler heads corrected. Missing ceiling tiles have been replaced.</p> <p>II This deficient practice could affect residents, staff and visitors of the building.</p> <p>III Re-education has been completed that no decorations may obstruct sprinkler heads. Maintenance has checked the building for sprinkler heads that are not in reliable operating condition and to assure that there are no decorations obstructing the sprinkler heads and that ceiling tiles are in place. Issues have been corrected.</p> <p>IV Maintenance completes environmental rounds to assure that no decorations obstruct sprinkler heads and that all sprinkler heads are in reliable and operating condition and that ceiling tiles are in place for three weeks and then monthly thereafter. Also that escutcheons are in place. Completed by</p>	08/10/2013			

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	<p>floor north stairwell had paint on the fusible link.</p> <p>b) The sprinkler head located in the 2nd floor west stairwell had paint on the fusible link.</p> <p>c) The sprinkler head located in the 1st floor south stairwell had paint on the fusible link.</p> <p>d) Two of three sprinkler heads located in the kitchen dishwashing area were covered with grease, dust and grime.</p> <p>e) Ten of ten sprinkler heads in the 1st floor shower room had paint, a greenish foreign material or rust on the fusible link and/or escutcheon.</p> <p>f) The sprinkler head by the door in room 132 had paint on the fusible link.</p> <p>Based on interview during the times of observation, the Maintenance Supervisor acknowledged the sprinkler heads had paint or foreign material on them.</p> <p>3.1-19(b)</p> <p>2) Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.1 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition</p>		8-10-13.				

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	<p>Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. These deficient practices potentially could affect clients, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. and on 7/11/13 from 8:45 a.m. to 11:30 a.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) The 1st floor classroom had decorations hanging from the ceiling (paper globes) six inches from the two sprinkler heads within the room.</p> <p>b) The sprinkler head above the three compartment sink in the kitchen was blocked by a light fixture.</p> <p>c) Ceiling tiles were missing or out of place in the following areas which could delay sprinkler system activation in the event of a fire:</p> <ol style="list-style-type: none"> 1) Basement electrical room 2) 3rd floor clean linen room 3) Room 218 bathroom 4) Room 108 small closet 5) 1st floor program office 			

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	<p>6) Reception office closet 7) 1st floor clean linen room d) Gaps around sprinkler heads or missing escutcheons in the following areas which could delay sprinkler activation in the event of fire:</p> <ol style="list-style-type: none"> 1) The sprinkler head above the three compartment sink in the kitchen 2) Recreation paper storage room 3) 3rd floor north hall near the set of smoke barrier doors 4) Room 218 bathroom 5) 2nd training room 6) Room 108 large closet <p>Based on interview during the times of observation, the Maintenance Supervisor acknowledged the aforementioned conditions existed which could effect sprinkler system performance.</p> <p>3.1-19(b)</p>			
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260			
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K010064	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>1) Based on observation and interview, the facility failed to inspect 3 of 16 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice was not in a client care area but could affect any number of staff in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) The monthly inspection tag on the two</p>	K010064	<p>K064 I Re-education has been completed with the Maintenance Director which states monthly inspection must occur for each fire extinguisher , all extinguishers must be securely installed, signage must be present on cabinets and hydrostatic testing must occur every six years.</p> <p>II This deficient practice could affect residents, staff and visitors of the building.</p> <p>III The list of location of each extinguisher is to be used as a checklist to check them monthly. Maintenance has checked each extinguisher in the building to assure they have been checked monthly, are secured by bracket or in cabinet, signage is present and hydrostatic testing has occurred as is required every six years.</p> <p>IV Maintenance completes environmental rounds to assure that each extinguisher in the building has been checked monthly, is secured by bracket or in cabinet, signage is present and hydrostatic testing has occurred as is required every six years for three weeks and then monthly thereafter. Completed by 8-10-13.</p>	08/10/2013			

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	<p>fire extinguishers located in the Maintenance/Generator room lacked documentation of a monthly inspection for the months of May and June of 2013</p> <p>b) The monthly inspection tag on the fire extinguisher located in the elevator machine room lacked documentation of a monthly inspection for the months of May and June of 2013</p> <p>Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2) Based on observation and interview, the facility failed to ensure 2 of 16 portable fire extinguishers was in accordance with NFPA 10, the Standard for Portable Fire Extinguishers. NFPA 10, 1-6.7 requires fire extinguishers shall be securely installed on the hanger or in the bracket supplied or placed in cabinets or wall recesses. This deficient practice could affect any clients and staff in the recreation room.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) The portable fire extinguisher located</p>			

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	<p>in the recreation room was placed on the floor next to the range. Based on interview at the time of observation, the Maintenance Supervisor acknowledged he was not aware the holder for the portable fire extinguisher had been pulled out of the wall.</p> <p>b) The portable fire extinguisher cabinet on the 3rd floor south hall lacked signage. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the decals had been pulled off.</p> <p>3.1-19(b)</p> <p>3) Based on observation and interview, the facility failed to ensure 1 of 16 portable fire extinguishers requiring a 12 year hydrostatic test were emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect any of the six residents on the third floor.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. with the Maintenance Supervisor., the maintenance tag on the fire extinguisher in the basement</p>						

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	<p>electrical room indicated the last six year test was completed in 2004. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>			

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K010070	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to ensure a policy and procedure was available for the operation 1 of 1 space heaters to ensure the unit was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice could affect clients and staff in the recreation room.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. with the Maintenance Supervisor, a portable space heater was plugged into a power strip in the recreation office. The device was not in use. The Maintenance Supervisor said at the time of observation, he was unaware there was a space heater in the facility. The Administrator was interviewed on 07/11/13 at 1:15 p.m. and provided a fire and electrical safety policy which covered heat producing appliance such as microwaves, hot plates or coffee machines but did not including space heaters. The Administrator said there was</p>	K010070	<p>K070</p> <p>I The space heater observed was removed 7-10-13.</p> <p>II This deficient practice could affect the staff in the recreation room.</p> <p>III Staff have been re-educated that space heaters are not to be used in the building.</p> <p>IV Maintenance completes environmental rounds to assure there are no space heaters weekly for three weeks and then monthly thereafter. Completed by 8-10-13.</p>	08/10/2013			

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	no policy available for the use of space heaters to identify where they might be used and any restriction related to their use in the facility 3.1-19(b)			

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K010071	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 3 laundry chute doors was provided with fire doors which were self closing and latching. This deficient practice could affect any client, staff or visitor on the 2nd floor.</p> <p>Findings include:</p> <p>Based on observation on 7/11/13 from 8:45 a.m. to 11:30 a.m. during the observation tour with the Maintenance</p>	K010071	<p>K071</p> <p>I The spring has been repaired on the laundry chute on the second floor.</p> <p>II This deficient practice could affect residents, staff and visitors to second floor.</p> <p>III Maintenance has checked the other two laundry chutes to assure the spring on the door is in good working condition.</p> <p>IV Maintenance checks laundry</p>	08/10/2013

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	Supervisor, the second floor soiled laundry chute door, located in the second floor soiled utility room had a broken spring and failed to close and latch into the frame. Based on an interview at the time of observation this was acknowledged by the Maintenance Supervisor. 3.1-19(b)		chute doors weekly for three weeks to assure they are in good working condition and then monthly thereafter. Completed by 8-10-13.	

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K010072	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency for 3 of 7 exits. This deficient practice could affect clients as well as staff and visitors throughout the facility.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) The 2nd floor west hall had two lifts blocking the exit stairwell door. b) The basement south exit stairwell had storage of wire shelving, three large cardboard boxes, one cart and a plastic stand obstructing the exit. c) The 1st floor south stair exterior exit door required excessive force to open. Based on interview at the times of observation, the Maintenance Supervisor acknowledged the aforementioned conditions.</p>	K010072	<p>K072 I Lifts do not obstruct the path of egress from the hall. Basement stairwells are not used for storage. The south exterior door is functioning properly.</p> <p>II This deficient practice could affect residents, staff and visitors.</p> <p>III Staff have been re-educated that lifts may not block the path of egress and on where to locate the lifts. Maintenance Director has been re-educated that stairwells are not to be used for storage. Maintenance has checked other exterior doors to assure they function properly.</p> <p>IV Maintenance environmental rounds to assure compliance with placement of lifts and assure they are properly located, stairwells are not used for storage and exterior doors function properly weekly for three weeks and then monthly thereafter. Completed by 8-10-13.</p>	08/10/2013			

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K010074	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 hanging curtains were flame retardant. This deficient practice could affect any client, staff and visitors on the 3rd and 2nd floor.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the orientation tour from 10:00 a.m. to 11:30 a.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) A portable privacy screen located on the 3rd floor west hall lacked attached documentation indicating it was inherently flame retardant.</p>	K010074	<p>K074</p> <p>I The curtains sited have been replaced with ones that have a flame resistance rating in accordance with NFPA 701.</p> <p>II This deficient practice could affect residents, staff and visitors.</p> <p>III Maintenance has checked the building for other curtains that do not meet NFPA 701.</p> <p>IV Appropriate curtains have been ordered if needed and maintenance director makes rounds weekly for 3 weeks and monthly thereafter to check for curtains that are not in accordance with NFPA 701. Completed by 8-10-13.</p>	08/10/2013			

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	<p>b) A portable privacy screen located on the 2nd floor west hall lacked attached documentation indicating it was inherently flame retardant. Based on interview at the time of observation with the Maintenance Supervisor, there was no documentation regarding flame retardancy for these curtains available for review.</p> <p>3.1-19(b)</p>			

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K010075	<p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for mobile soiled linen or trash collection receptacles was not exceeded within any 64 square foot area for 3 of 3 floors. This deficient practice could affect all clients including staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the orientation tour from 10:00 a.m. to 11:30 a.m., the observation tour from 2:30 p.m. to 5:30 p.m. and on 7/11/13 from 8:45 a.m. to 11:30 a.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) Two 32 gallon barrels were next to each other on the 3rd floor north hall. b) Two 32 gallon barrels were next to each other on the 3rd floor south hall. c) Two 32 gallon barrels were next to</p>	K010075	<p>K075 I Barrels are located at least 8 feet apart in the hallways.</p> <p>II This deficient practice could affect residents, staff and visitors.</p> <p>III Staff have been re-educated that barrels must be at least 8 feet apart.</p> <p>IV Maintenance Director checks weekly for 3 weeks to assure barrels are at least 8 feet apart in hallways and then checks monthly thereafter. Completed by 8-10-13.</p>	08/10/2013			

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	<p>each other on the 2nd floor west hall.</p> <p>d) Two 32 gallon barrels were next to each other on the 2nd floor south hall.</p> <p>e) Two 32 gallon barrels were next to each other on the 1st floor west hall.</p> <p>f) Two 32 gallon barrels were next to each other on the 1st floor south hall.</p> <p>Based on interview at the times of observation, the Maintenance Supervisor acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p>			

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K010130	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in client rooms for 12 of 12 months. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice affects all clients in the facility.</p> <p>Findings include:</p> <p>Based on review of "Battery-Operated Smoke Detector Maintenance Log for 2013 and 2012" with the Maintenance Supervisor from 11:30 a.m. to 2:30 p.m. on 07/10/13, the locations of the smoke detectors were not itemized on the form to document when each smoke detector was tested, cleaned and batteries replaced. Based on interview at the time of review, the Maintenance Supervisor acknowledged the form only documented smoke detectors that were found to have problems.</p> <p>3.1-19(b)</p>	K010130	<p>K130</p> <p>I Re-education has been completed with the Maintenance Director that smoke detectors must be checked in each bedroom monthly with accompanying documentation.</p> <p>II This deficient practice could affect residents, staff and visitors.</p> <p>III Maintenance has now checked each bedroom's smoke detector and documented same.</p> <p>IV Maintenance Director provides ED with copy of monthly checks. Completed by 8-10-13.</p>	08/10/2013			

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K010144	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1) Based on record review and interview, the facility failed to ensure a written record of weekly inspections of the starting batteries for the generator was maintained for 52 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. 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 by the authority having jurisdiction. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include: Based on interview and review of "Weekly Test-Emergency Generator"</p>	K010144	<p>K144 I Maintenance Director has been re-educated to complete weekly and monthly generator testing and document items as prescribed.</p> <p>II This deficient practice could affect residents, staff and visitors.</p> <p>III Maintenance Director has completed weekly generator testing and monthly generator testing for July 2013.</p> <p>IV Maintenance Director provides ED with copy of weekly and monthly generator testing. Completed by 8-10-13.</p>	08/10/2013

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	<p>documentation with the Maintenance Supervisor from 11:30 a.m. to 2:30 p.m. on 07/10/13, it could not be determined if the weekly testing was properly documented. The facility uses a computer based maintenance program for the generator and maintains documentation in an electronic format. There were discrepancies with dates and meter readings that could not be explained by the Maintenance Supervisor.</p> <p>3.1-19(b)</p> <p>2) Based on record review and interview, the facility failed to exercise the generator for 12 of 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. 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. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p>						

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	<p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview and review of "Monthly Test-Emergency Generator" documentation with the Maintenance Supervisor from 11:30 a.m. to 2:30 p.m. on 07/10/13, it could not be determined if the monthly testing was properly documented. The facility uses a computer based maintenance program for the generator and maintains documentation in an electronic format. There were discrepancies with dates and meter readings that could not be explained by the Maintenance Supervisor.</p> <p>3.1-19(b)</p>				

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K010147	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1) Based on observation and interview, the facility failed to ensure extension cords including powerstrips and non-fused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 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 would not affect clients but could affect staff in the maintenance office.</p> <p>Findings include:</p> <p>Based on observation on 07/10/13 during the observation tour from 2:30 p.m. to 5:30 p.m. with the Maintenance Supervisor, the following was noted:</p> <p>a) A multiplug adapter was plugged into an outlet in the maintenance office above the fish tank.</p> <p>b) A refrigerator in the 3rd floor nurse supply room was plugged into a power strip.</p>	K010147	<p>K147</p> <p>I Staff have been re-educated that they may not use power strips for refrigerators and that any use must be approved by maintenance.</p> <p>II This deficient practice could affect residents, staff and visitors.</p> <p>III Maintenance Director has checked the building for use of power strips and removed them if found improperly used.</p> <p>IV Maintenance checks the building for improper use of power strips weekly for 3 weeks and then monthly thereafter. Completed by 8-10-13.</p>	08/10/2013			

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	<p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2) Based on observation, the facility failed to ensure 2 of 2 electrical junction boxes observed was maintained in a safe operating condition. LSC 19.5.1 requires utilities 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 any client, visitor or staff using the 1st floor dining room.</p> <p>Findings include:</p> <p>Based on observation on 07/11/13 during the observation tour from 8:45 a.m. to 11:30 a.m. with the Maintenance Supervisor, there were two electrical junction boxes with numerous wire connections jutting out of the box without a cover in the 1st floor mechanical room.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor</p>						

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	acknowledged the aforementioned condition. 3.1-19(b)				

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K010154	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy indicating procedures to be followed in the event the automatic sprinkler system has to be placed out-of-service for 4 hours or more in a 24-hour period in accordance with LSC, Section 9.7.6.1. in order to protect 146 of 146 clients. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's "Fire</p>	K010154	<p>K154</p> <p>I ED has updated Fire Watch Policy to include contacting ISDH.</p> <p>II This deficient practice could affect residents, staff and visitors.</p> <p>III Fire Watch Policy is now included in ED and Maintenance Emergency Action Plan book.</p> <p>IV Fire Watch Policy will be reviewed annually with other Emergency Action Plan information. Completed by 8-10-13.</p>	08/10/2013			

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	<p>Protection System Impairments" policy and procedure on 07/10/13 during paperwork review from 11:30 a.m. to 2:30 p.m., the fire watch procedure for an out of service automatic sprinkler system was not complete. The policy and procedure did not include notification to the Indiana State Department of Health which is an authority having jurisdiction. Based on interview at the time of review, the Maintenance Supervisor acknowledged the fire watch policy and procedure omitted the requirement for notifying the Indiana State Department of Health.</p> <p>3.1-19(b)</p>			

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K010155	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to ensure its written fire watch policy addressed all procedures to be followed in this facility in the event the fire alarm system has to be placed out-of-service for 4 hours or more in a 24-hour period in accordance with LSC, Section 9.6.1.8. in order to protect 146 of 146 clients. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's "Fire Protection System Impairments" policy and procedure on 07/10/13 during paperwork review from 11:30 a.m. to 2:30 p.m., the fire watch procedure for an out of service fire alarm system was not complete. The policy and procedure did not include notification to the Indiana State Department of Health which is an authority having jurisdiction. Based on interview at the time of review, the Maintenance Supervisor acknowledged the fire watch policy and procedure</p>	K010155	<p>K155 I ED has updated Fire Watch Policy to include contacting ISDH.</p> <p>II This deficient practice could affect residents, staff and visitors.</p> <p>III Fire Watch Policy is now included in ED and Maintenance Emergency Action Plan book.</p> <p>IV Fire Watch Policy will be reviewed annually with other Emergency Action Plan information. Completed by 8-10-13.</p>	08/10/2013			

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	omitted the requirement for notifying the Indiana State Department of Health. 3.1-19(b)				