

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E281	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/11/2012
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NAME OF PROVIDER OR SUPPLIER  GOSPORT NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 27 S SEVENTH ST GOSPORT, IN 47433
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/11/12</p> <p>Facility Number: 000409 Provider Number: 15E281 AIM Number: 100291270</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Gosport Nursing Home was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully</p>	K0000	<p>It is the policy of Gosport Nursing Home to be in compliance with Life Safety Code. Please accept the following as our plan of correction. Smoke detectors were installed in all resident rooms. Installation was monitored by facility Administrator. Installation was complete on 7/6/12. 9/4/12 Please accept the following as addendum to our plan of correction. Thank you</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. There are no smoke detectors in resident rooms. The facility has the capacity for 74 residents and had a census of 42 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/18/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>			

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K0018 SS=E	<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. Based on observation and interview, the facility failed to ensure corridor doors in 1 of 2 resident room wings were equipped with working latches. This deficient practice affects staff, visitors and 34 residents in the West wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/11/12 between 12:30 a.m. and 1:30 p.m., the corridor doors to rooms 102 and 112 did not latch. The maintenance director acknowledged at the time of observations, the doors did not</p>	K0018	All door stops were removed on 6/29/12. New locks and door plates were put in place on attached rooms and adjusted to close properly by maintenance personnel on 7/2/12. All work was monitored by facility Administrator.	07/06/2012			

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	latch securely into their door frames.  3.1-19(b)				

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K0022 SS=E	<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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 paths in the south exit discharge from the East Wing was clearly identified. This deficient practice affects visitors, staff and 8 residents on the East Wing.</p> <p>Findings include:</p> <p>Based on observation with RN # 1 and the Director of Nurses (DON) on 06/11/12 at 11:20 a.m., the south exit from the East Wing discharged onto an asphalt surface with a gated six foot fence. One gate opened onto grassy irregular terrain which could not be maintained in inclement weather. A cracked and unlevel asphalt pathway made a right turn inside the fence toward the front of the facility. RN # 1 and the DON were asked at the time of observation, which path of exit was designated for evacuation? The two each chose</p>	K0022	Gate was removed on 7/2/12 to reflect correct way to exit South exit of East Wing. Sign posted to remain a non-gated exit. To be monitored by maintenance supervisor.	07/02/2012			

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	<p>the gate leading to the grassy terrain and, as an alternate, the irregular asphalt pathway. Based on an interview with the maintenance director on 06/11/12 at 11:30 a.m., a section of the fence directly opposite the south exit from the East wing was actually hinged and could be opened onto the level asphalt surface for evacuation of residents. The administrator was interviewed on 06/11/12 at 2:30 p.m. and identified the hinged fence section as the correct evacuation exit way. The maintenance director said at that time of interview, staff were unaware because he had never told anyone. There was no sign to indicate the correct path to use on the gate fence.</p> <p>3.1-19(b)</p>			

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K0025 SS=E	<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 openings through smoke barriers in 3 of 5 smoke compartments were protected to maintain the smoke resistance of the smoke barrier openings. 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 could affect visitors, staff and 34 or more residents in the East wing and central smoke compartments which includes the</p>	K0025	Maintenance Supervisor sealed Gaps and penetrations with fire and smoke rated material on 7/3/12. To be monitored in the future by the Administrator.	07/03/2012	

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	<p>main dining room.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 06/11/12 at 12:00 p.m., the west wing attic smoke barrier fire wall was unsealed around two conduit penetrations into the south smoke compartment leaving one half to one inch gaps and the north attic smoke barrier for the West wing had two inch pipe penetrations which were unsealed. The maintenance director agreed at the time of observations the gaps should have been sealed with a fire rated material.</p> <p>b. Based on observation with the maintenance director on 06/11/12 at 11:40 a.m., a two inch hole was noted in the ceiling and a one inch gap was unsealed around a pipe penetration in the wall of the east laundry. The maintenance director said at the time of observation, "The pipe goes into the attic."</p> <p>3.1-19(b)</p>						

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K0029 SS=E	<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 provide automatic door closers on 3 of 8 doors providing access to hazardous areas. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors close automatically upon activation of the fire alarm system. This deficient practice could affect visitors and 4 or more staff in the service corridor and 40 or more residents accessing the adjacent dining rooms.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 06/11/12 at 11:40 a.m., the door</p>	K0029	<p>Door stop was removed on 7/2/12. New door latching with lock was installed on 7/2/12. To be monitored by Administrator. Addendum: Rooms 213 &amp; 214 were placed back into normal use as patient rooms, which do not require door locks and/or automatic door closures. Room 216 has a lock and a closure placed on door. Stop was removed. Corrected 7-20-12. To be monitored by Administrator and Maintenance Supervisor.</p>	07/02/2012

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	<p>to room 216, a former resident room used for the storage of combustible wood products, paper, cardboard and fabric covered equipment was equipped with a kick down door stop to prevent the door from closing. The door had a two inch circular hole and no latch. The maintenance director acknowledged at the time of observation, the door could not always self close, latch into the door frame and prevent the passage of smoke.</p> <p>b. Based on observation with the maintenance director on 06/11/12 at 11:45 a.m., the door to room 213 used for storing furniture had no self closer and could not close due to furniture placed in front of the open door. The maintenance director said at the time of observation, the furniture could prevent the door from closing.</p> <p>c. Based on observation with the maintenance director on 06/11/12 at 11:46 a.m., the door to former resident room 214 was used as a storage room for mattresses, paper products, plastic material, cardboard and</p>			

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	fabrics. There was no self closer on the door. The maintenance director said at the time of observations, the door could not be relied upon to be closed to prevent the passage of smoke.  3.1-19(b)				

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K0038 SS=E	<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>Based on observation and interview, the facility failed to ensure 3 of 7 emergency exits were readily accessible at all times. LSC 7.1.10.1 requires a means of egress shall be continuously maintained free of all obstructions or impediments to full and instant use in case of fire or other emergency. This deficient practice affects visitors, staff and 12 or more residents on the East Wing and the lower dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/11/12 between 10:30 a.m. and 2:30 p.m., exit egresses for the north and south exits from the East Wing and the north exit near the east laundry providing access to evacuation points were blocked. The south exit corridor from the East wing had a three by three foot wooden table sitting in the corridor and three wheelchairs</p>	K0038	All obstructions were removed on 6/18/12 to make clear hall exits. Housekeeping Supervisor and Maintenance to monitor in the future.	06/18/2012			

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	<p>were parked in front of the exit door. The north exit from the East wing had two wheelchairs parked in front of the exit door. The short exit corridor outside the east laundry was blocked by a laundry cart. The maintenance director agreed the exit doors and exit access corridors would have to be cleared before exiting.</p> <p>3.1-19(b)</p>			

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K0046 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 8 of 19 battery powered emergency lighting fixtures would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice could affect visitors, staff and 34 or more residents.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/11/12 between 10:30 a.m. and 2:30 p.m., the battery powered emergency lighting failed to illuminate when tested twice:</p> <ul style="list-style-type: none"> <li>a. Near the west laundry exit, interior and exterior;</li> <li>b. At the main entry/exit, interior and exterior;</li> <li>c. The south exit from the West Wing, interior and exterior;</li> <li>d. The south exit from the East wing, interior and exterior;</li> </ul> <p>The maintenance director said at</p>	K0046	Emergency battery checked by a certified electrician and were repaired or replaced as needed on 6/22/12. Work was monitored by Administrator and complete on 6/22/12.	06/22/2012	

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	<p>the time of observations, he did not know the lights were not working.</p> <p>3.1-19 (b)</p>				

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K0048 SS=F	<p>NFPA 101 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. 19.7.1.1</p> <p>1. Based on record review and interview, the facility failed to keep all employees informed of the fire plan including the path of exit discharge for evacuation of 8 of 42 residents. This deficient practice affects visitors, staff and 8 residents on the East Wing.</p> <p>Findings include:</p> <p>Based on observation with RN # 1 and the Director of Nurses (DON) on 06/11/12 at 11:20 a.m., the south exit from the East Wing discharged onto an asphalt surface with a gated six foot fence. One gate opened onto grassy irregular terrain which could not be maintained in inclement weather. A cracked and unlevel asphalt pathway made a right turn inside the fence toward the front of the facility. RN # 1 and the DON were asked at the time of observation, which path of exit was designated for evacuation? The two each chose the gate leading to the grassy</p>	K0048	<p>Gate was removed and sign posted on 7/2/12. Maintenance Supervisor to monitor in the future. Fire and evacuation plans posted near each evacuation route in corridors and exit ways by Administrator on 7/2/12. To be monitored by Administrator. Addendum: 7/23/12 A mandatory in-service was given on 7-19-12 to in-service staff and supervisors regarding fire watch procedure and location of fire &amp; evacuation plans. Fire and evacuation plans are posted at corridor or in corridor exits. To be monitored by Administrator and DON. Corrected 7/19/12</p>	07/02/2012	

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	<p>terrain, and as an alternate, the irregular asphalt pathway. Based on interview with the maintenance director on 06/11/12 at 11:30 a.m., a section of the fence directly opposite the south exit from the East wing was actually hinged and could be opened onto the level asphalt surface for evacuation of residents. The administrator was interviewed on 06/11/12 at 2:30 p.m. and identified the hinged fence section as the correct evacuation exit way. The maintenance director said at that time of interview, staff were unaware because he had never told anyone.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to provide a written fire plan which includes the procedures for the use of all types of fire extinguishers in the facility for the protection of 42 of 42 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan which shall provide policy and</p>			

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	<p>procedures for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice could affect all occupants, visitors and staff in the facility in the event of an emergency when the written fire plan should be immediately available.</p> <p>Findings include:</p> <p>Based on interview with the Maintenance Director and Director Of Nurses (DON) on 06/11/12 at 2:05 p.m., there was no disaster manual or other written fire plan. The DON was asked to check further with the administrator and a manual was produced with a Fire Alert Procedure dated 2005. The floor plan provided as evidence of exit evacuation routes was poorly</p>			

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	<p>marked and had no marking to indicate the route to be taken to reach the public way. The Maintenance Director said he was not familiar with the plan and diagrams and the DON confirmed she had never seen these except for diagrams posted on walls.</p> <p>3.1-19(b)</p>				

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K0050 SS=F	<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 record review and interview, the facility failed to ensure all elements of fire drills were included on documentation of fire drills for 4 of the past 4 quarters. LSC 19.7.1.2 requires fire drills in health care facilities shall include the use of alarms, transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on a review of Inservice Training Class Report-Fire Drills for the past year with the maintenance director on 06/11/12 at 1:55 p.m., fire drill documentation did not include the use and transmission of the alarm and the fire conditions simulated.</p>	K0050	Fire Drills had been held on all shifts as required on a quarterly basis: However; sing in logs had been misplaced stated who was present and when drills were held. Better documentation will be available in future. DON and SSD will hold drills and maintain records. To be monitored by the DON/Designee.	07/11/2012			

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	<p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 2 of the last 4 quarters. This deficient practice could effect all patients, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's Inservice Training Class Report-Fire Drills and interview with the maintenance director on 06/11/12 at 1:55 p.m., there were no records of first shift fire drills during the last quarter of 2011 and first quarter of 2012. The Maintenance Director said documents provided were all there was for fire drill documentation.</p> <p>3.1-9(b) 3.1-51(c)</p>				

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K0051 SS=F	<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 provide annunciation for 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all occupants.</p> <p>Findings include:</p>	K0051	A certified electrician checked annunciator and nursing station and repaired a loose connection to annunciator on 7/5/12. To be monitored by Maintenance Supervisor and Administrator.	07/05/2012

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	<p>Based on observation with the maintenance director on 06/11/12 at 2:10 p.m., the fire alarm control panel (FACP) was located in a mechanical room 35 feet from the West Wing nurses station. A trouble alarm could not be heard at the nurses station which is monitored 24 hours per day. Documentation provided by the maintenance director during record review at 2:05 p.m. noted an additional relay was added at the West Nurses station to provide the audible trouble alarm. This annunciator was identified by the maintenance director on 06/11/12 at 2:15 p.m., was function tested, and failed to provide any trouble alarm. The maintenance director said at the time of testing, he was unaware it was not working.</p> <p>3.1-19(b)</p>				

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K0062 SS=F	<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 record review, observation and interview; the facility failed to ensure 2 of 2 automatic sprinkler system gauges were replaced or calibration tested every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 2-3.2. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on a review of sprinkler system maintenance and test reports with the maintenance director on 06/11/12 at 2:00 p.m., no information for the replacement or recalibration of sprinkler system gauges was</p>	K0062	<p>Quarterly inspections of fire alarm system is provided by Intergrated Electronics and was lost. Inspected and documented on 7/4/12, as in compliance with Fire Safety Codes. To be monitored by Mainenance Supervisor and Administrator. All items hanging from storand room piping were removed on 6/18/12. To be monitored by Maintenance Supervisor. All missing sprinler head escutheons were located and returned to places as needed on 6/18/12. To be monitored by Maintenance Supervisor. Tape has been removed from sprinkler head protecting exit discharge canopy over the northeast exit. The two sprinkler heads protecting west laundry and the three sprinkler heads in kitchen will be cleaned.Addendum 7/23/12We have notified our quarterly sprinkler inspection company, Integrated Electronics &amp; Pipe Inc. of Greenwood, IN, of the need to calibrate or replace gauges as needed. Work is to be completed on 7/24/12. Gauges are to be tagged and dated at that time.To be monitored by Maintenance Supervisor and Administrator.</p>	07/30/2012			

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	<p>found. The maintenance director said at the time of record review, he had no idea when the sprinkler system pressure gauges might have been replaced or undergone a calibration test. Dates of 2004 and 2006 were observed on the gauges with the maintenance director on 06/11/12 at 1:40 p.m. The maintenance director said at the time of observation, he did not know the gauges needed to be replaced or calibrated.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure piping for 1 of 1 automatic sprinkler systems was maintained free of external loads. NFPA 25, 2-2.2.2 requires sprinkler piping shall be not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/11/12 at 11:00 a.m., an</p>				

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	<p>automatic sprinkler system pipe in the East Wing supply storage room was used as a hanger for two walking canes and another unidentified item. The maintenance director said at the time of observation, he was unaware the pipe was used this way.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure sprinkler heads providing protection for 6 of 6 smoke compartments were maintained. This deficient practice could affect all staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/11/12 between 10:30 a.m. and 11:45 a.m., sprinkler head escutcheons were missing from sprinkler heads in the lower dining room and in resident room 202. The maintenance director acknowledged at the time of observations the missing escutcheons were a part of the</p>				

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	<p>sprinkler assembly.</p> <p>Based on observation with the maintenance director on 06/11/12 at 10:40 a.m. the sprinkler head protecting the exit discharge canopy over the northeast exit was covered with tape. The maintenance director said at the time of observation, the tape was put there to protect the sprinkler head during painting "a while back".</p> <p>Based on observation with the maintenance director on 06/11/12 between at 11:45 a.m. and 12:50 p.m., the two sprinkler heads protecting the west laundry and three sprinkler heads in the kitchen were coated with a gray fuzzy grime. The maintenance director said at the time of observation he didn't know about it.</p> <p>3.1-19(b)</p>				

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K0064 SS=F	<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 provide 3 of 10 portable fire extinguishers with a verification of service collar. NFPA 10, the Standard for Portable Fire Extinguishers, at 4-4.4.2 requires each extinguisher that has undergone maintenance which includes internal examination or has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch. Each extinguisher that has undergone</p>	K0064	All portable fire extinguishers were rechecked by Intergrated Electronics Inc. in April of 2012. Tags if certification were punched and changed at that time. Will have a fire extinguisher company test and check all fire extinguishers. Will have a fire extinguisher company check, test, and tag all fire extinguishers. This will be monitored by the Maintenance Supervisor.	07/30/2012

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	<p>the six year maintenance procedure shall have a "Verification of Service Collar" around the neck of the extinguisher indicating date of 6 year maintenance. This deficient practice could affect occupants in 3 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/11/12 between 11:10 a.m. and 12:30 p.m., portable fire extinguishers in the the corridors near room 210 and 105 were each manufactured in 1997. The fire extinguisher near 117 had a 1998 manufacture date. A sticker on the cylinders indicated hydrotesting had been done in 2010, however, the extinguishers each lacked the required verification of service collar. The maintenance director said at the time of observation, he didn't know a collar was required.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to</p>				

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	<p>ensure annual and monthly checks were provided for 6 of 10 portable fire extinguishers. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. NFPA 10, 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance that extinguisher will operate effectively and safely. NFPA 10, 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. This deficient practice could affect affect visitors, staff and residents in 3 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/11/12 between 11:00 a.m. and 12:30 p.m., service and inspection</p>			

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	<p>tags on portable fire extinguishers located in the facility indicated they had been placed in service in April 2012. Service and inspection tags on fire extinguishers located in the corridor near the kitchen, near rooms 210 and 105, near the East Wing supply storage room, in the lower dining room, and the kitchen (K-class) extinguisher noted no monthly check since they were placed in service. The maintenance director said at the time of observation, the only record of a monthly fire extinguisher check would have been noted on these service and inspection tags. He said he had checked them but didn't note the inspection.</p> <p>3.1-19(b)</p>			

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K0067 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure corridors were not used as part of a return air system serving adjoining areas in 2 of 5 smoke compartments. NFPA 90A, 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice affects visitors, staff and 34 residents on the northwest and southwest wings.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/11/12 between 10:30 a.m. and 2:20 p.m., egress corridors in the northwest and southwest wings smoke compartments were used as return air plenums for adjacent rooms. The ventilation arrangement was confirmed by the maintenance director at the time of observation.</p>	K0067	There is no central air returns in corridors of East wing servicing exit corridors. All patient rooms have a single A/C unit only. Exit corridors have no returns. Addendum 7/23/12 See request for waiver dated 7/22/12.	06/30/2012			

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	3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E281	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  06/11/2012
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K0076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <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. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 cylinders of nonflammable gases was properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect visitors, staff and 34 or more residents in the central smoke compartment where the dining room is located.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K0076	E-cylinder was secured and chained on 6/30/12 by maintenance supervisor. To be monitored by Maintenance Supervisor in the future.	06/30/2012	

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	<p>Maintenance Director on 06/11/12 at 12:00 p.m., one oxygen e-cylinder was stored without support in the oxygen supply storage room on a shelf above two liquid oxygen containers and three e-cylinders. The maintenance director said at the time of observation, he didn't know the cylinder was unsupported.</p> <p>3.1-19(b)</p>				

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K0130 SS=F	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review, and interview; the facility failed to ensure 4 of 4 service water heaters (SWH) had unexpired certificates of inspection. LSC 19.1.1.3 requires all health facilities to be maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/11/12 between 10:30 a.m. and 2:30 p.m., certificates of inspection were not posted for SWH # 297691 and # 297692. Certificates of inspection which expired in May of 2009 were provided for SWH # 000396 and # 923854 during a review of maintenance records on 06/11/12 with the maintenance director, who said at the time of observations and record review he thought the blue tags on the</p>	K0130	Service water heater was inspected by Steven L. Pauley of the Department of Home Land Security on 5/18/11. See attached invoice of state of 6/17/2011.	08/03/2012			

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	<p>vessels were all that was needed. The administrator was interviewed on 06/11/12 at 2:20 p.m. He said the vessel inspections were current but provided no further documentation.</p> <p>3.1-19(b)</p>				

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K0143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfer sites was separated from any portion of the facility wherein residents are housed by a fire barrier of 1 hour fire resistive construction. This deficient practice affects staff, visitors and 34 or more residents in the central smoke compartment where the main dining room is located.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 06/11/12 at 12:00 p.m., the</p>	K0143	Light bulb was replaced to make oxygen transfer are safe for transfer on 6/27/12.To be monitored by Maintenance Supervisor.	06/27/2012			

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	<p>oxygen transfer room was identified by signs and by the Maintenance Director as the oxygen transfer area. The light was out in the room. The Maintenance Director said at the time of observation, staff could bring the liquid oxygen tanks into the corridor to fill portable tanks, since they could not see in the room provided for the purpose.</p> <p>3.1-19(b)</p>			

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K0147 SS=E	<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 8 of 20 East Wing wet locations were provided with GFCI (ground fault circuit interrupter) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, 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 visitors, staff and 8 residents on the East Wing.</p> <p>Findings include:</p> <p>Based on observations with the maintenance director on</p>	K0147	<p>CFCI tp be checked by Certified Electrician and corrected.To be monitored by the Maintenance Supervisor.All extension cords were removed and/or electric items moved closer to electrical outlet on 6/30/12.To be monitored by Maintenance Supervisor.</p>	07/11/2012

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	<p>06/11/12 between 10:30 p.m. and 2:30 p.m., electrical outlets in bathrooms in the south smoke compartment of the East Wing bathrooms were located near sinks. The outlets were not provided with GFCI (ground fault circuit interrupter) to prevent electric shock. The maintenance director said at the time of observations, these outlets were protected by a GFCI circuit in the electrical panel. The GFCI function of the circuit was tested twice with the maintenance director, and it failed to function.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring in 2 of 5 smoke compartments. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect visitors, staff, and 10 or more residents in the south</p>						

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	<p>East wing and Central smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/11/12 at 11:10 a.m., an extension cord was used to supply power to a microwave and refrigerator in the activities office; a telephone and air conditioner in room 210; a refrigerator in the kitchen; and a refrigerator in the West Wing clean utility room. The maintenance director said at the time of observations, he was unaware the extension cords were in use.</p> <p>3.1-(19)b</p>				

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K0155 SS=F	<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 observation and interview, the facility failed to provide a written policy containing procedures to be followed to protect 42 of 42 residents in the event the fire alarm system has to be placed out of service for four hours or more within a 24 hour period. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Alert Procedures provided by the Director of Nurses on 06/11/12 at 1:55 p.m., the Fire Watch Policy and Procedure provided addressed the initiation of and procedures for an outage of the sprinkler system. There was no documentation for the implementation of a fire watch if the fire alarm system was out of</p>	K0155	<p>A fire watch procedure is located in policy and procedure manual and in documentation of fire drill, and also in each hall that is designated as an evacuation route Procedure is approved and monitored by Administrator. Addendum: 7/23/12 A mandatory in-service was given on 7-19-12 to in-service staff and supervisors regarding fire watch procedure and location of fire &amp; evacuation plans. Fire and evacuation plans are posted at corridor or in corridor exits. To be monitored by Administrator and DON. Corrected 7/19/12</p>	07/30/2012			

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	<p>service for four hours in a twenty four hour period. The Director of Nurses said at the time of record review, she was new and not familiar with these policy requirements.</p> <p>3.1-19(b)</p>			