

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/15/2012
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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/15/12</p> <p>Facility Number: 000112 Provider Number: 155205 AIM Number: 100288710</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist, Robert Sutton, Life Safety Code Specialist Trainee</p> <p>At this Life Safety Code survey, Greencroft Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a partial basement was determined to be of Type V (111) construction and was fully sprinklered except for the areas noted in K-56. The facility has a fire alarm system</p>	K0000	<p>F 000 Initial Comments</p> <p>This plan of correction constitutes Greencroft Healthcare's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission of or that a deficiency exists, or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. The facility has consulted with Dan Ware from Inter Design, an architect from Indianapolis for best practice recommendations of this Life Safety 2567. We respectfully request a desk review of this Plan of Correction.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>with smoke detection in the corridors except for the Therapy wing and the Gables nursing unit and in all spaces open to the corridors. Hard wired smoke detectors that provide a visual and audible signal at the nurses' station were provided in all 127 resident rooms. The facility has a capacity of 240 and had a census of 215 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered except where noted by K-56. All areas providing facility services were provided with sprinkler coverage except where noted by K-56.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/22/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0011 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire door sets separating the facility from a residential unit was arranged to automatically close and latch. In addition, NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects at least 20 residents, staff or visitors using the corridor leading to the Manor III building.</p> <p>Findings include:</p> <p>Based on observation with the Head of Healthcare Maintenance and the Director of Environmental Services on 10/15/12 from 2:30 p.m. to 5:00 p.m., the 90 minute fire rated doors separating the Healthcare Center from the Manor III building were not provided with latching hardware and were only held closed when the doors were magnetically locked after</p>	K0011	<p>K 011 NFPA 101 Life Safety Code Standard The doors identified in deficiency K011 of this 2567 were inspected by A1 Door Corporation on November 1, 2012. A1 Door Corporation has agreed to install the latching hardware to the doors connecting Manor III and Healthcare (Attachment I). The installation will be completed no later than December 15, 2012. The installation may occur prior to this date based on contractor availability. A monthly Preventative Maintenance (PM) check occurs on all doors. The Director of Maintenance will report the findings of the PM to the QI committee quarterly for review and recommendation. Alleged date of compliance: November 1, 2012.</p>	11/01/2012			

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	<p>hours. This was acknowledged by the Head of Healthcare Maintenance and the Director of Environmental Services at the time of observation.</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>1. Based on observation and interview, the facility failed to ensure 1 of 9 hazardous areas such as a kitchen was separated from other spaces by smoke resistive partitions and doors. This deficient practice could affect at least 20 residents, visitors and staff using the Sideboard Restaurant or the dining room and corridor.</p> <p>Findings include:</p> <p>Based on observation with the Head of Healthcare Maintenance and the Director of Environmental Services on 10/15/12 from 2:30 p.m. to 5:00 p.m., the Sideboard Restaurant was not separated from the Sideboard dining room and corridor. Kitchen appliances provided in the Sideboard Restaurant included two deep fryers, a charbroiler and a griddle. Based on interview during the time of</p>	K0029	<p>K 029 NFPA 101 Life Safety Code Standard The facility has discontinued use of the equipment identified in deficiency K029 of this 2567. The power has been shut off to this equipment. The equipment will not be used until approved self-closing doors connected to the fire alarm system are installed in the smoke partician surrounding this area. The acting Director of Food Services will monitor the equipment weekly and report findings quarterly to the QI committee for review and recommendation. Alleged date of compliance: November 1 st 2012. An inspection of the building was conducted for areas that need self closing doors in case of a fire. The resident activity door will have a closure added that is connected to the fire alarm system. The activity office door</p>	12/14/2012	

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	<p>observation, the Head of Healthcare Maintenance and the Director of Environmental Services acknowledged the Sideboard Restaurant was not separated from the dining room and corridor.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 8 doors serving hazardous areas such as areas storing combustible materials larger than 50 square feet closed and latched to prevent the passage of smoke. This deficient practice could affect at least 10 residents, visitors and staff in the corridor outside the activity room and office.</p> <p>Findings include:</p> <p>Based on observation with the Head of Healthcare Maintenance and the Director of Environmental Services on 10/15/12 at 3:45 p.m., the following was noted:</p> <p>a. The resident activity room door did not self close and latch into the frame. At the time of observation, a hot oil pop corn popper was observed in use and in addition, combustible storage such as books and magazines were stored in the room. Based on interview during the time of observation, the Head of Healthcare Maintenance and the Director of</p>		<p>will be replaced with a new self closing latch and door. This will be connected to the fire alarm system. Byler Construction will complete the work no later than November 30, 2012. The work may be completed earlier based on contractor availability. Activities staff were in-serviced and trained on fire extinguishers and awareness of potential fire risks within their area. Fire extinguishers were added to affected area.</p> <p>Alleged date of compliance: December 14, 2012.</p>		

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	<p>Environmental Services acknowledged the resident activity room door did not self close and latch into the door frame.</p> <p>b. The activity office door did not self close and latch into the frame. At the time of observation, a large quantity of combustible materials were stored in the activity office which was over 50 square feet in size. Based on interview during the time of observation, the Head of Healthcare Maintenance and the Director of Environmental Services acknowledged the activity office door did not self close and latch into the door frame.</p> <p>3.1-19(b)</p>			

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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 the means of egress through 10 of 10 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice affects at least 32 of 215 residents and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Head of Healthcare Maintenance and the Director of Environmental Services on 10/15/12 from 2:30 p.m. to 5:00 p.m., exit access doors throughout the facility were magnetically locked and could be opened by entering a four digit code which was</p>	K0038	<p>K 038 NFPA 101 Life Safety Code Standard A code identify card was created to display the exit code at the exit doors. The Environmental Services morning rounds will verify that the code cards are visible at the affected doors and correct any deficiency that exist. This will be recorded on the ES Morning Round Sheet (Attachment A). The Director of Environmental Services will submit the Morning Round Sheet to the Administrator weekly. The Director of Environmental Services will report findings to the QI committee quarterly for review and further recommendations. Alleged date of compliance: November 6 th , 2012.</p>	11/06/2012			

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	<p>not posted, or by swiping an access card carried by staff. Based on interview at the exit conference at 5:30 p.m. on 10/15/12, the Administrator indicated approximately 85 percent of the residents have a clinical diagnosis to be in a secure building. Any resident without a clinical diagnosis requiring specialized security measures or any visitor would have to ask a staff member for exit access if they did not know the code.</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 Based on record review and interview, the facility failed to include the use of fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice affects any resident, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's written fire safety plan and policy and procedures regarding the extinguishment of fire with the Head of Healthcare Maintenance and the Director of Environmental Services on 10/15/12 from 11:45 a.m. to 2:00 p.m., the fire safety plan addressed grease fires and when to use the K-class extinguisher</p>	K0048	<p>K 048 NFPA 101 Life Safety Code Standard The orientation and annual in-service materials were reviewed for accuracy. The Director of Environmental Services will in-service staff on use of extinguisher operation (Attachment F). The orientation record sheet was updated to include extinguisher procedure (Attachment G). The Director of Environmental Service will report changes and/or inconsistencies to QI committee quarterly for review and recommendation Alleged date of compliance: November 6, 2012.</p>	11/06/2012			

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	<p>but did not address how to use portable fire extinguishers or what other types of fire extinguishers were provided throughout the facility. Based on interview at the time of record review, the Director of Environmental Services indicated facility staff are not trained in the use of portable fire extinguishers.</p> <p>3.1-19(b)</p>				

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K0050 SS=C	<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>Based on record review and interview, the facility failed to conduct fire drills at unexpected times under varying conditions in first and second shift fire drills. This deficient practice affects all residents in the facility as well as staff.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report Form" documentation with the Head of Healthcare Maintenance and the Director of Environmental Services on 10/15/12 at 12:30 p.m., five of seven first shift fire drills were conducted between 10:00 a.m. and 11:00 a.m. and three of five second shift fire drills were conducted between 2:00 p.m. and 3:00 p.m. as follows:</p> <p>First Shift 02/27/12 10:10 a.m. 06/29/12 11:00 a.m. 07/18/12 10:45 a.m.</p>	K0050	<p>K 050 NFPA 101 Life Safety Code Standard The 2012 (Attachment B) and 2013 (Attachment C) Fire Drill schedule has been reviewed by the Administrator & the Director of Environmental Services. The 2013 Fire Drill schedule has been adjusted to reflect unexpected times of drills by varying days and times of fire drills. The QI committee will review the fire drill times for the previous quarter to ensure that the drills were performed at various days and times. The QI committee will also review the scheduled fire drills for the upcoming quarter to ensure various days and times and recommend changes as needed. Alleged date of compliance: November 13 th , 2012.</p>	11/13/2012			

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	<p>08/22/12 10:17 a.m. 10/15/11 10:00 a.m.</p> <p>Second Shift 02/29/12 2:55 p.m. 09/21/12 2:30 p.m. 11/01/11 3:00 p.m.</p> <p>Based on interview at the time of record review, the time of day the first and second shift fire drills were conducted was acknowledged by the Head of Healthcare Maintenance and the Director of Environmental Services.</p> <p>3.1-19(b) 3.1-51(c)</p>				

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K0051 SS=E	<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>1. Based on observation and interview, the facility failed to ensure an automatic smoke detector system was installed in all corridors in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.4.5.1.1 requires detector spacing in the corridor to be every 30 feet. This deficient practice could affect residents, staff, and visitors throughout the Therapy wing and Gables nursing unit.</p> <p>Findings include:</p> <p>Based on observation with the Head of Healthcare Maintenance and the Director of Environmental Services on 10/15/12</p>	K0051	<p>K 051 NFPA 101 Life Safety Code Standard A building inspection was conducted for air vent distance. We moved all noncompliant air vents to an appropriate distance. Alleged date of compliance: November 1, 2012. Resident room smoke detectors in the Gables will be connected to a fire alarm system for the facility so that any room detector will initiate a general alarm. Per NFPA18.3.4.5.3 exception #1 "corridor systems shall not be required where each patient sleeping room is protected by an approved smoke detection system" (Attachment E). Simplex is the vendor used for fire detectors and a representative</p>	11/01/2012			

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	<p>from 2:30 p.m. to 5:00 p.m., automatic hard wired smoke detectors electrically interconnected to the fire alarm system were not provided every 30 feet within the corridors of the Therapy wing and Gables nursing unit. Based on interview at the time of observation, the Head of Healthcare Maintenance and the Director of Environmental Services acknowledged hard wired smoke detectors electrically interconnected to the fire alarm system were provided at the smoke barriers but not in each resident room.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 5 of 90 smoke detectors connected to the fire alarm system were properly separated from an air supply. 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 residents, staff, and visitors throughout the facility.</p> <p>Findings include:</p> <p>Based on observation with the Head of Healthcare Maintenance and the Director of Environmental Services on 10/15/12</p>		<p>evaluated the needed work on October 30, 2012. Simplex will complete the needed changes no later than November 30, 2012. This may be completed earlier based on contractor availability. Staff in the effected areas will be in-serviced by November 10 th , 2012 on the operation of resident room smoke detector and the need for immediate response. Alleged date of compliance: October 30, 2012.</p>		

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	<p>from 2:30 p.m. to 5:00 p.m., the following was noted:</p> <ul style="list-style-type: none"> a. The smoke detector located in the corridor in front of the resident store was one foot from an air vent. b. The smoke detector identified as # 72 located in the corridor (outside room 331) was one foot from an air vent. c. The smoke detector identified as # 73 located in the corridor (outside room 335) was one foot from an air vent. d. The smoke detector identified as # 95 located in the corridor (outside room 206) was one foot from an air vent. e. The smoke detector located in the Occupational Therapy hallway was one foot from an air vent. <p>Based on interview at the time of observation, the Head of Healthcare Maintenance and the Director of Environmental Services acknowledged the distances between the vents and agreed the air flow could interfere with smoke detector function.</p> <p>3.1-19(b)</p>				

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K0056 SS=E	<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>1) Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided in 3 of 5 Nursing Units and 1 of 1 basements in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice could affect any resident, staff and/or visitors on the North, South and Central Nursing Units.</p> <p>Findings include:</p> <p>Based on observation with the Head of Healthcare Maintenance and the Director of Environmental Services on 10/15/12 from 2:30 p.m. to 5:00 p.m., the following areas were not provided with sprinkler coverage:</p>	K0056	<p>K 056 NFPA 101 Life Safety Code Standard</p> <p>On Wednesday October 31 st , the building was inspected for missing sprinkler locations by representatives from Shambaugh Corporation. Shambaugh Corporation of Fort Wayne, IN has submitted a quote for additional heads in all noted locations. Shambaugh Corporation has agreed to install code approved sprinkler heads for all areas addressed in K056 of this 2567. This work is scheduled to be begin on November 5 th , 2012. The work may be completed prior to this date based on availability of the contractors. Shambaugh Corporation is our contracted fire protection company. They will provide quarterly monitoring and report to the Director of Maintenance.</p>	11/14/2012			

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	<p>a. A total of eight corridor linen closets on the South, North and Central Nursing Units hallways.</p> <p>b. The beauty shop closet</p> <p>c. South Unit Time Clock room</p> <p>d. Basement water softener room</p> <p>Based on interview during the time of observation, the Head of Healthcare Maintenance and the Director of Environmental Services acknowledged these areas were not provided with sprinkler coverage.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>2. Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 5 combustible exterior canopies which was wider than 4 feet. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect residents, staff and visitors using the South Unit Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Head of Healthcare Maintenance and the Director of Environmental Services on 10/15/12 from 2:30 p.m. to 5:00 p.m., the canopy</p>		<p>The Director of Maintenance will report quarterly to the QI committee for review and recommendations.</p> <p>Alleged date of compliance: November 14, 2012 pending contractor schedule.</p>				

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	<p>of wood construction outside of Exit Door # 43 was not provided with sprinkler protection. Based on interview at the time of observation, the Head of Healthcare Maintenance and the Director of Environmental Services acknowledged the canopy was not provided with sprinkler protection.</p> <p>3.1-19(b) 3.1-19(ff)</p>			

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K0069 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to protect cooking equipment with a range hood extinguishing system in accordance with LSC Sections 9.2.3 and 19.3.2.6 and NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations in 1 of 4 pantry kitchens. NFPA 96, 7-1.2 requires cooking equipment that produces grease laden vapors (such as but not limited to deep fat fryers, ranges, griddles, broilers, woks, tilting skillets, and braising pans) shall be protected by fire extinguishing equipment. This deficient practice could affect any resident, as well as staff and visitors using the Gables pantry kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Head of Healthcare Maintenance and the Director of Environmental Services on 10/15/12 at 4:50 p.m., a Team Leader was observed frying fish with vegetable oil in a skillet on the stovetop in the Gables pantry kitchen under a range hood that lacked an extinguishing system. Based on interview during the time of observation, the Head of Healthcare Maintenance and the Director of Environmental Services</p>	K0069	<p>K 069 NFPA 101 Life Safety Code Standard The kitchen staff was in-serviced and educated on the "non-grease base cooking method" on November 5 th , 2012. Flammable base cooking products have been removed from the pantries. Signs have been posted in the pantries indicating the proper methods for preparing food items. The acting Director of Food Services or designee will monitor pantries daily for one month, weekly for one month, then quarterly for use of unapproved products. The acting Director of Foods Services will report findings to the QI committee quarterly for review and recommendation. Alleged date of compliance: November 6, 2012.</p>	11/06/2012			

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	acknowledged the pantry range hood was not provided with an extinguishing system. 3.1-19(b)			

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K0072 SS=E	<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 4 of 8 corridors. This deficient practice could affect residents as well as staff and visitors using the Central, South and North Nursing Unit corridors.</p> <p>Findings include:</p> <p>Based on observation with the Head of Healthcare Maintenance and the Director of Environmental Services on 10/15/12 during the orientation tour from 11:00 a.m. to 11:45 a.m. and the environmental tour from 2:30 p.m. to 5:00 p.m., the South Nursing Unit East, South Nursing Unit North, Central Nursing Unit East and North Nursing Unit East corridors were used for wheelchair and cart storage. Based on interview at the time of observation, the Head of Healthcare Maintenance and the Director of Environmental Services acknowledged</p>	K0072	<p>K 072 NFPA 101 Life Safety Code Standard Staff have been in-serviced and educated on corridors not being used for storage. Wheelchair and carts have been removed and placed in resident rooms or designated storage areas. The Director of Environmental Services will include compliance of wheelchair and walker storage with AM daily rounds (Attachment A). The Administrator on call will complete compliance rounds on weekends (Attachment H). The Director of Environmental Services will report findings to the QI committee quarterly for review and recommendation. Alleged date of compliance: November 5 th 2012.</p>	11/05/2012			

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	the corridors are used for storage of wheelchairs and carts when not in use. 3.1-19(b)				

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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>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 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 any resident, staff of visitor using the southeast hall of the Central Nursing Unit.</p> <p>Findings include:</p> <p>Based on observation with the Head of Healthcare Maintenance and the Director of Environmental Services on 10/15/12 from 2:30 p.m. to 5:00 p.m., a twenty foot orange extension cord was used as permanent wiring to provide power to a television in room 336.</p> <p>This was acknowledged by the Head of Healthcare Maintenance and the Director of Environmental Services at the time of observation.</p>			K0147	<p>K 147 NFPA 101 Life Safety Code Standard</p> <p>The extension cord was removed from room #336. In consultation with the resident, the room was rearranged to avoid the use of an extension cord.</p> <p>An environmental audit of the entire building was conducted for the use of extension cords. The Director of Environmental Services will monitor extension cord use daily. Any violations will be replaced with an approved electrical power strip and reported to the Administrator.</p> <p>The Director of Environmental Services will report findings of the environmental audit to the QI committee quarterly for review and recommendations.</p> <p>Alleged date of compliance: October 30, 2012.</p>		10/30/2012

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	3.1-19(b)			

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(a) The facility must be designed, constructed and maintained to protect the health and safety of residents, personnel and the public</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview; the facility failed to maintain a resident room smoke detector preventive maintenance program in 127 of 127 resident rooms. This deficient practice could affect 215 residents in the facility.</p> <p>Findings include:</p> <p>Based on observation and interview with the Head of Healthcare Maintenance on 10/15/12 between 2:30 p.m. to 5:00 p.m., the resident rooms were each provided with a hard wired smoke detector which when activated, provided an audible and visual signal at the nurses' station. Additionally, based on observation, each hard wired smoke detector had a listed sensitivity range. Based on interview at the time of observation, the Head of</p>	K9999	<p>K 9999 NFPA 101 Life Safety Code Standard</p> <p>The Preventative Maintenance System (PM) has been changed to test each resident room smoke detector per manufacturer published tech bulletin for compliance with NFPA72E (Attachment D). The PM is monitored by the Director of Maintenance for timely completion and compliance monthly. The Director of Maintenance will report the findings of this monitoring to the QI committee quarterly for review and recommendations Alleged date of compliance: November 13, 2012.</p>	11/13/2012			

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	Healthcare Maintenance indicated documentation of sensitivity testing of the resident room hard wired smoke detectors was not available for review. 3.1-19(a)				