

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155787	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/05/2014
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NAME OF PROVIDER OR SUPPLIER  INDIANA VETERANS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3851 N RIVER RD WEST LAFAYETTE, IN 47906
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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 483.70(a).</p> <p>Survey Dates: 06/05/14</p> <p>Facility Number: 001134 Provider Number: 155787 AIM Number: 200817200</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Indiana Veterans Home 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 facility located in three buildings identified as Mitchell Hall (3 story), Pyle Hall (3 story) and MacArthur Hall (4 story) was determined to be of Type I (443) construction and fully sprinklered. The buildings were surveyed as one since they were all constructed prior to March</p>	K010000		

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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K010020 SS=E	<p>1, 2003. MacArthur and Pyle Halls have basements. There is a partial basement under the mechanical room on Mitchell Hall. The facility has a fire alarm system with hardwired smoke detectors in corridors, in common areas and in resident rooms. The facility has a capacity of 197 and a census of 174 residents.</p> <p>All areas where residents have customary access were sprinklered with the exception cited at K9999. Areas providing facility services were sprinklered except the detached generator building, maintenance shop building, and detached chapel cited at K9999.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/12/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				
	NFPA 101 LIFE SAFETY CODE STANDARD				

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	<p>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 a pipe chase for 1 of 4 wings was enclosed with construction providing a fire resistance of at least one hour. This deficient practice could affect visitors, staff and and 20 or more residents on the Mitchel third floor A hall.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops on 06/05/14 at 1:25 p.m., the A wing pipe chase was unsealed at the ceiling around the chilled water supply pipe at the third floor leaving an annular one inch gap into the penthouse above. A second pipe penetrated the wall into the adjacent break room leaving an unsealed annular gap of 3/4 inches. The Director of Plant Ops acknowledged at the time of observation, the opening compromised the one hour fire rating of the pipe enclosure.</p> <p>3.1-19(b)</p>	K010020	<p><b>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice?</b> Seal all affected pipes, which have gaps compromising the 1 hour fire rating, with 3M Caulking.</p> <p><b>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective Action (s) will be taken?</b> Inspect other areas with similar situations in all buildings, document and fix.</p> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur again?</b> Contractor Check Off sheet to be completed and documented that will be given to all future contractors to make sure they cover boxes and use fire caulking as required.</p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place?</b> PM to inspect quarterly will be entered into our MP2 system</p> <p><b>5. By what date the systemic changes will be completed?</b> Completed By:</p>	07/05/2014

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K010025 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 ceiling and wall smoke barrier penetrations in 2 of 6 sprinklered smoke compartments in the MacArthur basement and first floor were sealed in a manner which maintains the one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a</p>	K010025	<p>Complete sealing pipes affected 7/5/14</p> <p>Complete inspection of all buildings 6/30/14</p> <p>Contractor Sign off Sheet Complete</p> <p>PM Inspection starting every quarter after 7/5/14 7/5/14</p> <p><b>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice?</b> Remove all expandable spray foam in affected areas and seal areas with 3M Caulking</p> <p><b>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> Inspect other areas with similar situations in all buildings and replace</p>	07/05/2014

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	<p>material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. LSC Section 8.3.2 requires smoke barriers to be continuous from floor to ceiling and outside wall to outside wall. This deficient could affect visitors, staff and 20 or more residents in the Mac basement and first floor accessing services in the adjacent areas.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops and Maintenance Supervisor on 06/05/14 between 3:00 p.m. and 5:00 p.m., ceiling penetrations were sealed with expandable spray foam in the Mac Hall first floor laundry clean storage room, and mechanical room # 7 in the Mac Hall basement. The Director of Plant Ops acknowledged at the time of observations, he had no information regarding the fire resistance rating of the foam used to seal the penetrations.</p> <p>3.1-19(b)</p>		<p>with proper 3M chalking.</p> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur again?</b></p> <p>Contractor Check Off sheet to be completed and documented that will be given to all future contractors to make sure they cover boxes and use fire caulking as required.</p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place?</b></p> <p>PM to inspect quarterly will be entered into our MP2 system</p> <p><b>5. By what date the systemic changes will be completed?</b></p> <p><b>Completed By:</b></p> <p>Complete removal of expandable foam 7/5/14</p> <p>Complete inspection of all buildings 6/30/14</p> <p>Contractor Sign off Sheet 7/5/14</p> <p>Complete PM Inspection starting every quarter after 7/5/14</p>		

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K010029 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 ensure 2 of 20 doors to hazardous areas, such as a soiled linen storage rooms and maintenance repair shops on Mac and Mitchell halls, closed automatically or upon activation of the fire alarm system and latched.</p> <p>Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects visitors, staff and 30 or more residents on the second floor of Mitchell Hall and the basement of Mac Hall.</p> <p>Findings include:</p> <p>a. Based on observation with the Director of Plant Ops and Maintenance Supervisor on 06/05/14 at 1:30 p.m., the soiled utility room near the 2 Mitchell nurses</p>	K010029	<p><b>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice?</b></p> <p>1. Remove dead bolts from Mitchell Kitchen door and Mitchell 2CD soiled linen room</p> <p>2. Install Self-Closure on door MacArthur Basement Maintenance Shop.</p> <p><b>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>Inspect other doors with similar situations in all buildings</p> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur again?</b></p> <p>1. Inform / train maintenance proper procedures on doors and latches.</p> <p>2. A Maintenance PM for Door Closures generates every 120 days</p>	07/05/2014			

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K010046	<p>station was used for the collection of soiled linens in a 20 cubic foot receptacle which was full. The self closing access door was equipped with a deadbolt latch as the only means to secure it into the door frame. The Maintenance Supervisor noted at the time of observation, the automatic door latching mechanism had been removed. The Director of Plant Ops agreed at the time of observation, the door could not automatically close and latch into the door frame.</p> <p>b. Based on observation with the Director of Plant Ops and Maintenance Supervisor on 06/05/14 at 5:00 p.m., the maintenance shop in the Mac Hall basement had no self closer. The Director of Plant Ops acknowledged at the time of observation, the door could not automatically close.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		<p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place?</b></p> <p>1. A PM will be generated to do a widespread sweep to check for doors every 6 months.</p> <p>2. A Maintenance PM for Door Closures generates every 120 days</p> <p><b>5. By what date the systemic changes will be completed?</b></p> <p><b>Completed By:</b></p> <p>Completion of removal of dead bolts 7/5/14</p> <p>Completion of install self-closure 6/10/14</p> <p>Train / inform maintenance proper procedures 7/01/14</p> <p>Inspection of all buildings and complete every 6 months 6/30/14</p> <p>PM Inspection (s)-every 120 days 7/5/14</p>				

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SS=D	<p><b>LIFE SAFETY CODE STANDARD</b> 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 1 of 2 battery powered emergency lighting fixtures in the laundry would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors and 2 or more laundry staff.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops and Maintenance Supervisor on 06/04/14 at 2:30 p.m., the battery powered emergency light fixture above the laundry room storage area failed to operate when tested twice by the Maintenance Supervisor. The Maintenance Supervisor acknowledged at the time of observation, the fixture was not working.</p> <p>3.1-19 (b)</p>	K010046	<p><b>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice?</b> Battery powered emergency light failed to operate. Maintenance will replace batteries ASAP.</p> <p><b>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> Inspect all emergency lights in all buildings and corrected as necessary.</p> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur again?</b> A Maintenance PM to test all Emergency Lights generates every 30 in each building.</p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place?</b> A Maintenance PM is in effect to inspect all emergency lights are every 30 days for 30 minutes and every 120 days for 90 minutes and will be audited by safety department every quarter..</p> <p><b>5. By what date the systemic changes will be completed?</b></p>	07/05/2014			

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 provide automatic sprinkler protection for the detached chapel. This deficient practice could affect visitors, staff and 20 or more residents in the chapel.</p> <p>Findings include:</p>	K010056	<p><b>Completed By:</b> Repair/Replace Emergency light 6/10/14 Complete inspection of all buildings and repair as needed 7/05/14 Generate safety PM to inspect quarterly 7/05/14</p> <p><b>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice?</b> The Chapel at the Indiana Veterans' Home is not equipped with a fire sprinkler system. The chapel will remain closed until evaluations are complete.</p> <p><b>2. How other residents having the potential to be affected by the</b></p>	07/04/2014

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K010062 SS=E	<p>Based on observation with the Physical Plant Director and Maintenance Supervisor on 06/05/14 at 3:00 p.m., sprinkler protection did not cover the detached chapel building. The Executive Director said during an interview on 06/05/14 at 5:15 p.m., the chapel was used by residents during fair weather; otherwise religious services were conducted in the auditorium.</p> <p>3.1-19(ff)</p> <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>Based on observation and interview, the facility failed to ensure 2 of 2 boxes storing spare automatic sprinkler heads were in a location where the temperature did not exceed 100 degrees Fahrenheit</p>	K010062	<p><b>same deficient practice will be identified and what corrective action(s) will be taken?</b> All other areas will be inspected ASAP</p> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur again?</b></p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e., what quality assurance program will be put into place?</b></p> <p><b>5. By what date the systemic changes will be completed?</b></p> <p style="text-align: center;"><b>Completed</b></p> <p><b>By:</b></p> <p>Chapel was closed on 6/16 and will remain closed until further evaluations</p> <p><b>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice?</b> Sprinklers heads found in room with high temperatures. The boxes in</p>	07/05/2014	

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	<p>(F) as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 2-4.1.4. NFPA 25, 2-4.1.4 requires the spare sprinkler head cabinet shall be so located that it will not be exposed to moisture, dust, corrosion, or a temperature exceeding 100 degrees F. This deficient practice could affect all occupants in the Mac Hall.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops and the Maintenance Supervisor on 06/05/14 at 3:45 p.m., two spare sprinkler head cabinets hung on the wall in the "tunnel" where steam radiated from service piping located there. A portable air conditioner had been installed to cool one section of the pipe to prevent overheating. The Maintenance Supervisor measured the temperature around the room at 120 degrees Fahrenheit (F) and 165 degrees F. The two staff were visible perspiring within minutes of entering the room and commented, "it gets hot in here." The Director of Plant Ops acknowledged at the time of observation, the room was above the maximum temperature permitted to store the sprinkler heads and steam could facilitate their corrosion.</p>		<p>question were moved to a cooler area.</p> <p><b>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> All mechanical rooms were inspected for heat and sprinkler heads will be removed if necessary.</p> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur again?</b> Safety Department will do an audit of all rooms and sprinkler heads will be moved to a controlled environment. This will be done by a maintenance PM and will be completed every 6 months.</p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place?</b> A Maintenance PM will be entered into system to have Safety Employees to inspect semi-annually</p> <p><b>5. By what date the systemic changes will be completed?</b></p> <p style="text-align: center;"><b>Completed By:</b> Completion of removal of sprinkler heads 7/01/14 Inspection all mechanical rooms for proper storage 7/05/14 A Maintenance PM will be entered</p>				

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K010064 SS=E	<p>3.1-19(b)</p> <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 Based on observation and interview, the facility failed to ensure portable fire extinguishers in 4 of 12 Mac Hall service areas were installed on a hanger, bracket, mounted in a cabinet or set on a shelf. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1-6.6 requires that extinguishers shall be installed on the hangers or in the brackets supplied, mounted in cabinets or set on shelves. NFPA 10 1-6.7 requires extinguishers installed under conditions where they are subject to dislodgement shall be installed in brackets specifically designed to cope with this problem. This deficient practice could affect visitors, staff and any resident accessing services in adjacent</p>	K010064	<p>into system 7/05/14</p> <p><b>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice?</b> Fire extinguishers may not be setting on any floors; they must be stored correctly by state codes in all mechanical rooms. All of our extinguishers were inspected by safety and will be mounted or placed on a shelves.</p> <p><b>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> Inspect all fire extinguishers for proper storage in all buildings and repair if necessary.</p> <p><b>3. What measures will be put into place or what systemic changes</b></p>	07/05/2014
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NAME OF PROVIDER OR SUPPLIER  INDIANA VETERANS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 3851 N RIVER RD WEST LAFAYETTE, IN 47906			
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K010070 SS=E	<p>areas of the Mac Hall basement and first floor.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops and Maintenance Supervisor on 06/05/14 between 11:30 a.m. and 4:00 p.m., fire extinguishers sat on the floor in the Mac Hall laundry, first floor Mac Hall mechanical room, the "tunnel" mechanical room, and the elevator room. The Director of Plant Ops said at the time of observations, he was unaware the fire extinguishers had not been secured on wall brackets.</p> <p>3.1-19(b)</p> <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, record review, and interview; the facility failed to provide evidence 5 of 5 space heaters were</p>	K010070	<p><b>will be made to ensure that the deficient practice does not occur again?</b></p> <p>This deficiency will be added to the existing Maintenance PM and checked for proper storage..</p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place?</b> A safety PM will be generated every 30 days for all buildings.</p> <p><b>5. By what date the systemic changes will be completed?</b></p> <p style="text-align: center;"><b>Completed By:</b></p> <p>Completion of fire extinguishers correctly stored 7/05/14 Complete Inspection of all buildings 7/01/14 Safety PM Inspection for proper storage – 30 days</p> <p><b>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice?</b></p>	07/05/2014			

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	<p>equipped with heating elements which would not exceed 212 degrees Fahrenheit (F). This deficient practice affects visitors, staff and 30 or more residents on the first floor of MacArthur Hall and basement and first floors of Mitchell Hall.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plants Ops and Maintenance Supervisor on 06/05/14 between 11:30 a.m. and 5:00 p.m., space heaters were observed in the central supply office and laundry on the first floor of Mitchell Hall, the social services office on Mac 3, and the radiology room and storage room # 2 located in the basement of MacArthur Hall. A review of the facility space heater policy and procedure with the Director of Plant Ops on 06/05/14 at 5:05 p.m., indicated space heaters were permitted in nonresident areas when the heating element did not exceed 212 degrees Fahrenheit (F). The Director of Plant Ops said at the time of record review, he had no evidence the space heating elements would not exceed the 212 F degree limit.</p> <p>3.1-19(b)</p>		<p>Remove all space heaters from all offices/rooms in all buildings</p> <p><b>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> Inspect all building/rooms for a similar situation.</p> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur again?</b> This deficiency will be added to an existing Maintenance PM for all buildings</p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place?</b> This Maintenance PM generates every 30 days</p> <p><b>5. By what date the systemic changes will be completed?</b></p> <p style="text-align: right;"><b>Completed By:</b></p> <p>Completion of removal of all space heaters 7/5/14</p> <p>Completion of inspection 7/01/14</p> <p>Maintenance PM Inspection 7/5/14</p>				

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure 1 of 1 alcohol based hand sanitizers in room Mac 406 was not installed over an ignition source. This deficient practice could affect visitors, staff and 10 or more residents on Mac 4.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops and Maintenance Supervisor on 06/05/14 at 3:30 p.m., an alcohol based hand sanitizer was located above the electrical outlet in Mac 406. The Maintenance Supervisor acknowledged at the time of observation, the hand sanitizer was alcohol based.</p> <p>3.1-19(b)</p>	K010130	<p><b>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice?</b> Hand sanitizer dispenser must be moved from above an ignition source (electrical outlet).</p> <p><b>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective Action will be taken?</b> Inspect all areas with similar situations in all buildings and remove if necessary.</p> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur again?</b> A PM will be generated to inspect all buildings every 6 months by safety personnel to look for possible violations.</p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place?</b> This Maintenance PM generates every 30 days for each building</p>	07/05/2014

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K010147 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 5 of 5 electrical wiring connections were maintained in a safe operating condition which included junction boxes. 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 visitors, staff and 30 or more residents on Mitchell 2 and 3.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops and the Maintenance Supervisor on 06/05/14 between 11:30</p>	K010147	<p><b>5. By what date the systemic changes will be completed?</b></p> <p><b>Completed By:</b> Completion of moving dispenser in report 6/10/14 Completion of building inspections 7/5/14 Safety PM Inspection every 6 months 7/5/14</p> <p><b>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice?</b> 1. Junction boxes must be covered in all areas in the ceilings in Mitchell 2. Equipment used for cooling in the MacArthur Basement must be plugged into a GFCI outlet where, at any time, water can pool next to electrical cords.</p> <p><b>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> 1. Inspect other area with similar situations in all buildings and replace electrical covers if needed. 2. Inspect all plugs and remove if necessary.</p>	07/05/2014	

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	<p>a.m. and 5:00 p.m., junction boxes above the lay in ceiling were left uncovered with multiple wires exposed:</p> <p>a. Near room 330 on D wing, Mitchell Hall;</p> <p>b. At the third floor B wing smoke barrier on Mitchell Hall;</p> <p>c. Near room 300 on A wing, Mitchell Hall;</p> <p>d. At the second floor D wing smoke barrier, Mitchell Hall;</p> <p>e. Near room 220, second floor, Mitchell Hall.</p> <p>The Maintenance Supervisor said at the time of observations, it appeared a contractor had failed to cover the wiring during recent work.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 3 building facility services equipment areas in a wet location was provided with ground-fault circuit interrupter (GFCI) protection against electric shock. 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 could affect any visitors and staff accessing</p>		<p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur again?</b> 1. A contractor check off sheet to be completed and documented to ensure all codes is enforced. 2. Safety will do a complete inspection and if necessary all lines will be "hard wired" in to system direct...eliminating plugs and lying on floors.</p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e., what quality assurance program will be put into place?</b> A Maintenance PM will be entered into our system to inspection both problems listed above. Contractor Check Off sheet to be completed and documented that will be given to all contractors</p> <p><b>5. By what date the systemic changes will be completed?</b></p> <p style="text-align: right;"><b>Completed By:</b></p> <p>Lids for the boxes will be re-installed by maintenance 6/30/14 Cords laying on floors will be removed from water 6/30/14 Contractor Sign off Sheet</p> <p style="text-align: right;">Complete Safety will be generated to inspect for missing lids and cords 7/05/14</p>				

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	<p>equipment in the "tunnel."</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Ops and the Maintenance Supervisor on 06/05/14 at 3:50 p.m., a portable air conditioning unit was located in a "tunnel" equipment with a flexible duct loosely attached to the permanent duct serving equipment in the room. The air conditioning power cord was plugged into a receptacle attached to a heavy gauge cord to allow power to reach the unit. The receptacle and air conditioning unit plug lay on the floor where water had pooled nearby. The Director of Plant Ops said at the time of observation the arrangement was required to cool equipment in the room and keep it functioning. The Maintenance Supervisor measured the air temperature in the room at 120 and 165 degrees Fahrenheit. The Director of Plant Ops acknowledged at the time of observation, the power connection for the unconventional cooling installation for the equipment was at risk from water damage and did little to cool the area.</p> <p>3.1-19(b)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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