

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/31/2016
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NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 0000  Bldg. 01	<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: 05/31/16</p> <p>Facility Number: 000275 Provider Number: 155656 AIM Number: 100290930</p> <p>At this Life Safety Code survey, Canterbury Nursing and Rehabilitation Center 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 an attached partial second story office wing was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in all resident rooms.</p>	K 0000	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the department's inspection report. Canterbury Nursing and Rehabilitation Center respectfully request a desk review.</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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K 0021 SS=E Bldg. 01	<p>The facility has a capacity of 142 and had a census of 84 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility had a detached garage providing facility services including the emergency generator room, storage of the mower, maintenance equipment and supplies that was not sprinklered.</p> <p>Quality Review completed on 06/06/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <p>(a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2</p> <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.</p>			
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	<p>Based on observation and interview, the facility failed to ensure 1 of 2 kitchen corridor doors were held open only by a device which would allow it to close automatically upon activation of the fire alarm system. This deficient practice could affect up to 50 residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 05/31/16 at 1:20 p.m., the door leading from the dining room into the kitchen dish washer side was propped open with a plastic dish. Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K 0021	<p>K-021 Life Safety Code Standard: Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <p>(a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or are required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2</p> <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>- The door to the kitchen's dish rooms was propped open. Maintenance Director immediately removed the prop to close the door, and educated dietary staff.</p> <p>- No other residents were affected, but all residents in the main dining room were at risk by deficient practice. Maintenance Director did an audit of the entire facility to ensure no other doors were propped open.</p>	06/30/2016

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K 0025 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 6 of 7 smoke barrier walls were protected to maintain the smoke resistance of each smoke	K 0025	·Maintenance Director or designee toconduct follow up checks anytime a delivery has been made to the facility toensure that doors are not propped open.  To ensure compliance, Maintenance Director or Designeeis responsible for the completion of the CQI Environmental Audit tool. 1xweek 4 weeks, bi weekly 1x week 4 weeks, if outcome is under allotted threshold thenwill reduce audits to, monthly x 6 months and then to follow CQI presetschedule thereafter. The results ofthese audits will be reviewed by the CQI committee overseen by the ED. Ifthreshold of 95% is not achieved an action plan will be developed to ensurecompliance. Dateof Completion: 6/30/2016  K-025 Life Safety Code Standard: Smoke barriers shall be constructed toprovide at least a one half hour fire resistance rating and constructed inaccordance with 8.3. Smoke barriers shall be permitted to	06/30/2016	

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	<p>barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice affects all residents in all smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 05/31/16 from 2:00 p.m. to 2:35 p.m., the following smoke barrier walls had unsealed penetrations:</p> <p>a) Above the ceiling tiles of the smoke barrier wall by room 545 there was an unsealed fourth of an inch penetration around a conduit.</p> <p>b) Above the ceiling tiles of the smoke barrier wall by room 537 there was an unsealed fourth of an inch penetration around a wire.</p> <p>c) Above the ceiling tiles of the smoke barrier wall by room 521 there was an unsealed hole measuring three inches by five inches in size.</p>		<p>terminate at an atriumwall. Windows shall be protected by fire-rated glazing or by wired glass panelsand steel frames.</p> <p>·Anunsealed area around the wire and conduit by rooms 545, 537, 521, 502, 216,entering 300 Hall, and by the 500 Hall Laundry Closet. These unsealed areas werefilled with fire caulk.</p> <p>·No other residents were affected, but all residents were at risk bydeficient practice. Maintenance Directorconducted a onetime audit with no additional findings.</p> <p>·Maintenance Director to conduct follow upchecks anytime a contractor has been in the facility to ensure the smokebarriers are maintained and will provide a one hour fire resistance rating.</p> <p>To ensure compliance, Maintenance Director or Designeeis responsible for the completion of the CQI Environmental Audit tool. 1xweek 4 weeks, bi weekly 1x week 4 weeks, if outcome is under allotted threshold thenwill reduce audits to, monthly x 6 months and then to follow CQI presetschedule thereafter. The results ofthese audits will be reviewed by the CQI committee overseen by the ED. Ifthreshold of 95% is not achieved an action plan will be developed</p>	

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	<p>d) Above the ceiling tiles of the smoke barrier wall by room 216 there was an unsealed three inch by four inch hole.</p> <p>e) Above the ceiling tiles of the smoke barrier wall by room 502 there was an unsealed fourth of an inch penetration around a conduit.</p> <p>f) Above the ceiling tiles of the smoke barrier wall entering the 300 hall there was an unsealed fourth of an inch penetration around a wire.</p> <p>Based on interview at the time of observation, the maintenance Supervisor acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 26 residents on the 500 hall.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor on 05/31/16 at 11:40 a.m., in the ceiling of the laundry closet on the 500 hall there were three unsealed one</p>		<p>to ensure compliance. Date of Completion: 6/30/2016</p>		

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K 0029 SS=E Bldg. 01	<p>fourth of an inch penetration around a wires, a three inch hole, and a half inch opening around a heating duct. Based on interview at the time of observation, the Maintenance Director acknowledge and provided the Measurements of the penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 1 of 2 hazardous areas on the 500 hall were smoke resistive. This deficient practice could affect 26 residents on the 500 hall.</p> <p>Findings include:</p> <p>Based on observation and interview during the tour with the Maintenance Supervisor on 5/31/16 at 12:40 p.m., the mechanical room on the 500 hall, which contained a fuel fired water heater, had</p>	K 0029	<p>K-029 Life Safety Code Standard: One hour fire rated construction (with o hour fire-rateddoors) or an approved automatic fire extinguishing system in accordance with8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automaticfire extinguishing system option is used, the areas areseparated from other spaces by smoke resisting partitions and doors. Doors are self-closing andnon-rated or field-applied protective plates that do not</p>	06/30/2016

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	seven unsealed half inch penetration around wires and conduits. Based on interview at the time of observation, the Maintenance Supervisor acknowledged and provided the measurements of the penetrations.  3.1-19(b)		<p>exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <ul style="list-style-type: none"> <li>·An unsealed area around the wire and conduit in the mechanical room on 500 Hall. These unsealed areas were filled with fire caulk.</li> <li>·No other residents were affected, but all residents were at risk by deficient practice. Maintenance Director conducted a one-time audit with no additional findings.</li> <li>·Maintenance Director to conduct follow-up checks anytime a contractor has been in the facility to ensure the smoke barriers are maintained and will provide a one-hour fire resistance rating.</li> </ul> <p>To ensure compliance, Maintenance Director or Designee is responsible for the completion of the CQI Environmental Audit tool. 1x week 4 weeks, bi-weekly 1x week 4 weeks, if outcome is under allotted threshold then will reduce audits to, monthly x 6 months and then to follow CQI pre-schedule thereafter. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Date of Completion: 6/30/2016</p>	

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K 0044 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self-closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice could affect 50 residents in the dining room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 05/31/16 at 1:35 p.m., the fire door set to the main dining room failed to latch into the frame. Based on interview at the time of observation, this was acknowledged and confirmed these were fire doors by the Maintenance Supervisor.</p> <p>3.1-19(b)</p>	K 0044	<p>K-044 Life Safety Code Standard: Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <ul style="list-style-type: none"> <li>·The fire door leading into the main dining room failed to properly self close. Maintenance Director fixed the closer.</li> <li>·No other residents were affected, but all residents in the main dining room were at risk by deficient practice. Maintenance Director conducted a one time audit with no additional findings.</li> <li>·Maintenance Director ordered and will replace the latch on the fire door leading into the main dining room.</li> </ul> <p>To ensure compliance, Maintenance Director or Designee is responsible for the completion of the CQI Environmental Audit tool. 1x week 4 weeks, bi weekly 1x week 4 weeks, if outcome is under allotted threshold then will reduce audits to, monthly x 6 months and then to follow CQI preschedule thereafter. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	06/30/2016
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K 0051 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 9 smoke detectors in the 500 hall were installed where air flow would not adversely affect their operation. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice</p>	K 0051	<p>Date of Completion: 6/30/2016</p> <p>K-051 Life Safety Code Standard: A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual</p>	06/30/2016

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	<p>could affect 26 residents in the 500 hall.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor on 05/31/16 at 11:11 a.m., the smoke detector in 500 hall by room 547 was located within three feet of an air supply duct. Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>means and by any required sprinkler system alarm, detection device, ordetection system. Manual alarm boxes are provided in the path of egress near eachrequired exit. Manual alarm boxes in patient sleeping areas shall not be requiredat exits if manual alarm boxes are located at all nurse's stations. Occupant notificationis provided by audible and visual signals. In critical care areas, visualalarms are sufficient. The fire alarm system transmits the alarm automaticallyto notify emergency forces in the event of fire. The fire alarm automatically activatesrequired control functions. System records are maintained and readilyavailable. 18.3.4, 19.3.4, 9.6</p> <p>·Thesmoke detector by room 547 was located within three feet of the air supplyduct. Maintenance Director documentedthe issue and moved the smoke detector.</p> <p>·No other residents were affected, but all residents were at risk bydeficient practice. MaintenanceDirector documented the issue and did a onetime facility audit to ensure noother smoke detector was within three feet of any air supply.</p> <p>·Maintenance Director moved the smokedetector outside of the needed three feet radius.</p>	

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K 0062 SS=F Bldg. 01	<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 record review and interview, the facility failed to ensure 2 of 2 dry sprinkler systems were maintained in proper working order. Once obstructive material is observed during an investigation as described in NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems at 10-2.1., NFPA 25, 10-2.3 requires a complete flushing program shall be conducted. The work shall be done by qualified personnel. This deficient practice affects all occupants.</p>	K 0062	<p>To ensure compliance, Maintenance Director or Designee is responsible for the completion of the CQI Environmental Audit tool. 1x week 4 weeks, bi weekly 1x week 4 weeks, if outcome is under allotted threshold then will reduce audits to, monthly x 6 months and then to follow CQI preschedule thereafter. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Date of Completion: 6/30/2016</p> <p>K-062 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>According to internal pipe inspection, materials were found in the sprinkler system. Maintenance Director immediately contacted Executive Director and Regional Maintenance Director about the sprinkler system.</p>	06/30/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/31/2016
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NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835
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K 0064 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor on 05/31/16 at 10:00 a.m., the "Report of Inspection" from the Koorsen's internal pipe inspection on the two dry pipe sprinkler systems had the box checked stating "The sprinkler systems are in need of internal cleaning. Some of the pipes were found to be partially full of foreign materials". Based on an interview with the Maintenance Supervisor at the time of record review, there was no paper work available to show a system flush on either of the sprinkler systems.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p>		<p>·No other residents were affected, but all residents were at risk bydeficient practice. Regional MaintenanceDirectorcontacted qualified vendors to have the entire system flushed.</p> <p>·Maintenance Director will secure thequotes from the qualified vendors to ensure that the facilities sprinkler systemis properly flushed.</p> <p>To ensure compliance, Maintenance Director,Executive Director, and Regional Maintenance Director will work with homeoffice to proper ensure that the flushing of the sprinkler system is completedand done by qualified personnel. MaintenanceDirector or Designee is responsible for the completion of the CQI EnvironmentalAudit to ensure the completion occurs for the flushing of the sprinkler system. Dateof Completion: 6/30/2016</p>	
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	<p>Based on observation and interview, the facility failed to ensure 1 of 6 500 hall and 1 of 4 300 hall fire extinguishers were mounted so the top of the extinguisher was no more than five feet (60 inches) above the floor. NFPA 10, Section 1-6.10 requires fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than 5 feet (60 inches) above the floor. This deficient practice affects 42 residents in the 300 and 500 halls.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 05/31/16 between 11:35 a.m. to 12:30 p.m., the fire extinguishers mounted on the walls in the 500 hall by room 534 and in the 300 hall by room 305 were mounted over five feet in height. Based on interview at the time of observation, the Maintenance Supervisor confirmed both extinguishers were mounted over five feet.</p> <p>3.1-19(b)</p>	K 0064	<p>K-064 Life Safety Code Standard: Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p> <ul style="list-style-type: none"> <li>·Onefire extinguisher on 300 Hall and one fire extinguisher on 500 Hall were found to be over five feet. Maintenance Director immediately lowered the two fire extinguishers to proper height.</li> <li>·No other residents were affected, but all residents on 300 Hall and 500 Hall were at risk by deficient practice. Maintenance Director conducted a one time audit on the other fire extinguishers with no additional findings.</li> <li>·Maintenance Director to conduct follow up check on fire extinguishers after any construction or painting in the facility.</li> </ul> <p>To ensure compliance, Maintenance Director or Designee is responsible for the completion of the CQI Environmental Audit tool. 1x week 4 weeks, bi weekly 1x week 4 weeks, if outcome is under allotted threshold then will reduce audits to, monthly x 6 months and then to follow CQI preset schedule thereafter. The results of these audits will be reviewed by the CQI</p>	06/30/2016			

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K 0066 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observations and interview, the facility failed to ensure cigarette butts were disposed into a noncombustible container which was provided for 2 of 2 areas where smoking was permitted. This deficient practice could affect 20 residents using the 200 hall courtyard, and staff utilizing the service hall exit during a fire emergency.</p>	K 0066	<p>committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Date of Completion: 6/30/2016</p> <p>K-066 Life Safety Code Standard: Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted</p>	06/30/2016

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	<p>Findings include:</p> <p>Based on observations during the tour of the facility with the Maintenance Supervisor on 05/31/16 at 12:30 p.m. and 1:10 p.m., the staff smoking area outside of the service hall exit had 25 cigarette butts on the ground. The resident smoking area in the 200 hall court yard was provided with approved metal containers for disposing cigarette butts, but there was combustible trash mixed with cigarette butts. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the facility's employee and resident smoking areas had cigarette butts disposed with paper products or cigarette butts on the ground.</p> <p>3.1-19(b)</p>		<p>with signs that read NO SMOKING orwith the international symbol for no smoking. (2) Smoking by patientsclassified as not responsible is prohibited, except when under directsupervision. (3) Ashtrays of noncombustible material and safe design are providedin all areas where smoking is permitted. (4) Metal containers with self-closingcover devices into which ashtrays can be emptied are readily available to allareas where smoking is permitted. 19.7.4</p> <p>·Cigarettebutts were found on the ground by the employee smoking area, and trash was inthe approved metal container for disposing cigarette butts outside of 200 Hall.Maintenance Director immediately cleaned cigarette butts up in the employeesmoking area, and replaced the container outside of 200 Hall.</p> <p>·No other residents were affected, but all residents on 200 Hall wererat risk by deficient practice. MaintenanceDirector educated the staff and the residents that smoke.</p> <p>·Maintenance Director and or designee willconduct education and in-servicing for all resident and staff smokers.</p> <p>To ensure compliance,</p>		

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