

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155714	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/10/2012
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NAME OF PROVIDER OR SUPPLIER OAK VILLAGE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561
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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: 09/10/12</p> <p>Facility Number: 000517 Provider Number: 155714 AIM Number: 100266770</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code and Quality Assurance Walk thru survey, Oak Village, Inc. 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) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies.</p>	K0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective October 10, 2012 survey conducted on September 10 th , 2012	

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>This one story facility with a basement was determined to be of Type III (200) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on both levels including the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 50 and had a census of 35 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage and in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered, and all areas providing facility services were sprinklered, except the new Dining Room furnace closet and a detached garage used for a maintenance shop with maintenance and facility storage, plus oxygen storage.</p> <p>Quality Review by Robert Booher, Life Safety</p>				

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	Code Specialist-Medical Surveyor on 09/21/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0021 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 8 hazardous area room doors, such as a kitchen metal rolling door, was held open only by a device arranged to automatically close upon activation of the fire alarm system. This deficient practice could affect any of the 35 residents as well as staff and visitors while exiting the new dining room through the old dining room which is now part of the center east egress corridor.</p> <p>Findings include:</p> <p>Based on observation on 09/10/12 at 12:15 p.m. during a tour of the facility with the</p>	K0021	<p>K021 The corrective action taken for those residents found to have been affected by the deficient practice is that no specific residents were identified. The corrective action taken to identify those residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by the deficient practice. The action taken for those residents with the potential to be affected is that the rolling door in the kitchen area has been closed and sealed. The measures or systemic changes taken to ensure the deficient practice does not recur is that Maintenance has been in-serviced as to the regulation in NFPA 101 Life Safety Code Standard stating that any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous</p>	10/10/2012

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	<p>Maintenance Supervisor, the full wall metal rolling door between the kitchen and the old dining room, which is now part of the center east egress corridor, was held open with a chain and fusible link which would not allow the door to close automatically when the fire alarm system is actuated. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of the required manual fire alarm system; local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and the automatic sprinkler system, if installed. The corrective action taken to monitor to assure performance and compliance is that a Performance Improvement tool has been developed. This tool will be completed weekly times 3 weeks, monthly for 3 months and then quarterly times 3 quarters This tool will be monitored by the Administrator and reviewed in quarterly QA to see if further action is warranted.</p>		

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K0046 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review, interview and observation; the facility failed to ensure 1 of 1 battery powered light sets were tested monthly for 30 seconds and annually for 90 minutes. LSC 101, Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p>	K0046	<p>K046 The corrective action taken for those residents found to have been affected by the deficient practice is that no specific residents were identified. The corrective action taken to identify those residents having the potential to be affected by the same deficient practice is that all residents and staff have the potential to be affected by the deficient practice. The corrective action taken for those residents with the potential to be affected is that the emergency lighting has been tested for 90 minutes and was fully operational for the duration of the test. The measures or systemic changes taken to ensure the deficient practice does not recur is that Maintenance has been in-serviced to the requirement of all battery powered light sets are tested and results documented monthly for 30 seconds and annually for 90 minutes in accordance with LSC 101 Section 7.9.3 The corrective action taken to monitor to assure performance and compliance is that a Performance Improvement Tool has been implemented to assure the deficient practice does not recur. This tool will be completed by Maintenance monthly. This tool will be</p>	10/10/2012			

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	<p>Findings include:</p> <p>Based on review of the Battery Back Up Light Testing documentation on 09/10/12 at 9:15 a.m. with the Maintenance Supervisor present, there was no documentation to show the battery back up light set within the generator housing has been tested monthly for thirty seconds since 06/04/12, furthermore, there was no documentation of a ninety minute annual test within the past twelve months. Based on interview at the time of record review, the Maintenance Supervisor said there was no documentation available to show the battery back up light set within the generator housing had been tested monthly for thirty seconds since 06/04/12, and an annual ninety minute test within the past twelve months. Based on observation at 11:15 a.m. during a tour of the facility with the Maintenance Supervisor, the battery back up light set at the generator did light up when tested.</p> <p>3-1.19(b)</p>		<p>monitored by Administrator monthly and reviewed in quarterly QA to see if any further action is warranted. Completion date 10-10-12</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 ensure fire drills were held at varied times for 1 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drills book on 09/10/12 at 8:45 a.m. with the Maintenance Supervisor present, four of four second shift (evening) fire drills held since September of 2011 were performed between 2:15 p.m. and 3:00 p.m. During an interview at the time of record review, the Maintenance Supervisor acknowledged the times of the second shift fire drills were not varied.</p>	K0050	<p>K050 The corrective action taken for those residents found to have been affected by the deficient practice is that no specific residents were identified.</p> <p>The corrective action taken to identify those residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected. The corrective action taken for those residents with the potential to be affected is that a second shift fire drill has been conducted on 10-3-12 at 8:00pm.</p> <p>The measures or systemic changes taken to ensure the deficient practice does not recur is that Maintenance has been in-serviced on conducting fire drills at least quarterly on each shift, with a time variance that ensures that such drills are conducted at varying times, (two-three hours apart) each time.</p>	10/10/2012

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	3-1.19(b)		The corrective action taken to monitor to assure performance and compliance is that a Performance Improvement Tool will be completed by Maintenance monthly. This tool will be reviewed by Administrator. The results of this tool will be reviewed at QA meetings to see if further action is warranted.		

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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 record review, interview and observation; the facility failed to ensure 1 of 1 kitchen exhaust systems was cleaned at least semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1 requires systems serving moderate volume cooking operations shall be inspected semiannually. This deficient practice could affect any of the 35 residents as well as staff and visitors while exiting the new dining room through the old</p>	K0069	<p>K069 The corrective action taken for those residents found to have been affected by the deficient practice is that no specific residents were identified.</p> <p>The corrective action taken to identify those residents having the potential to be affected by the same deficient practice is that all residents, employees and visitors have the potential to be affected by the deficient practice The corrective action taken for those with the potential to be affected is that the range hood has been cleaned and inspected by Tri State Fire Protection Service.</p> <p>The measures or systemic changes taken to ensure the deficient practice does not recur is that Maintenance has been in-serviced on the requirement that the range hood in kitchen area be cleaned and inspected semi-annually.</p> <p>The corrective action taken to monitor to assure performance and compliance is that a Performance Improvement Tool has been implemented. This tool will be completed every six months by Maintenance. The tool will be monitored by the Administrator and reviewed in Quarterly QA to see if further action is warranted. Completion Date: 10-10-12</p>	10/10/2012	

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	<p>dining room which is now part of the center east egress corridor and in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on review of the kitchen range inspection reports in the Inspections folder on 09/10/12 at 10:15 a.m. with the Maintenance Supervisor present, there was no documentation to show the kitchen range hood had been cleaned within the past twelve months. This was acknowledged by the Maintenance Supervisor at the time of record review. Based on observation at 11:00 a.m. during a tour of the facility with the Maintenance Supervisor, there was no sticker on the kitchen range hood to indicated the range hood had been cleaned. This was confirmed by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>				

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K0144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all</p>	K0144	<p>K144. The corrective action taken for those residents found to have been affected by the deficient practice is that no specific residents were identified. The corrective action taken to identify those residents having the potential to be affected by the same deficient practice is that all residents, staff and visitors have the potential to be affected. The corrective action taken for those residents with the potential to be affected is that Maintenance has conducted a testing of the emergency generator providing power to the emergency light systems. The generator has been exercised under operating conditions of 30 percent of the EPS nameplate rating a minimum of 30 minutes in accordance with NFPA 99. 3.4.4.1 and will be tested for 30 minutes under operating conditions of 30 percent monthly 3.4.4.1 The measures or systemic changes taken to ensure the deficient practice does not recur is that Maintenance has been in-serviced to the requirement of testing the emergency generator providing power to the emergency light systems. Further that the generator will be exercised under operating conditions of 30 percent</p>	10/10/2012			

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	<p>residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Generator Log on 09/10/12 at 9:45 a.m. with the Maintenance Supervisor present, the generator log form documented the generator was tested weekly under load, however, there was no documentation on the form that showed the generator was exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes since September of 2011. During an interview at the time of record review, the Maintenance Supervisor confirmed the weekly generator log did not include documentation the generator was exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes.</p> <p>3.1-19(b)</p>		<p>of the EPS nameplate rating a minimum of 30 minutes per month in accordance with NFPA 99 3.4.4.1. Also, the results will be documented and available for inspection. The corrective action taken to monitor to assure performance and compliance is that a Performance Improvement Tool has been implemented to ensure the deficient practice does not recur. This tool will be completed monthly by Maintenance and reviewed by Administrator. The outcome will be reviewed in quarterly QA to see if further action is warranted.</p>		

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K0000	<p>A Life Safety Code, Environmental Preoccupancy and a Quality Assurance Walk_thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a) for the addition of a new Dining Room and two attached egress corridors.</p> <p>Survey Date: 09/10/12</p> <p>Facility Number: 000517 Provider Number: 155714 AIM Number: 100266770</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code, Environmental Preoccupancy and Quality Assurance Walk-thru survey, Oak Village, Inc. 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 18, New</p>	K0000			

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	<p>Health Care Occupancies, and with 410 IAC 16.2-3.1.19, Environmental and Physical Standards of Indiana's Health Facilities Rules for Comprehensive care facilities in regard to the Life Safety Code and Environmental Preoccupancy Survey for the addition of a new Dining Room and two attached egress corridors.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on both levels including the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. There are no resident sleeping rooms in the new Dining Room and attached egress corridors. The facility has a capacity of 50 and had a census of 35 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage due to lack of sprinkler coverage in the new Dining Room furnace closet, but in compliance with state law in</p>			

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	<p>regard to smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except, the dining Room furnace closet and a detached garage used for a maintenance shop with maintenance and facility storage, plus oxygen storage.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0046 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1</p> <p>Based on record review, interview and observation; the facility failed to ensure 1 of 1 battery powered light sets were tested monthly for 30 seconds and annually for 90 minutes. LSC 101, Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p>	K0046	<p>K046 The corrective action taken for those residents found to have been affected by the deficient practice is that no specific residents were identified. The corrective action taken to identify those residents having the potential to be affected by the same deficient practice is that all residents and staff have the potential to be affected by the deficient practice. The corrective action taken for those residents with the potential to be affected is that the emergency lighting has been tested for 90 minutes and was fully operational for the duration of the test. The measures or systemic changes taken to ensure the deficient practice does not recur is that Maintenance has been in-serviced to the requirement of all battery powered light sets are tested and results documented monthly for 30 seconds and annually for 90 minutes in accordance with LSC 101 Section 7.9.3 The corrective action taken to monitor to assure performance and compliance is that a Performance Improvement Tool has been implemented to assure the deficient practice does not recur. This tool will be completed by Maintenance monthly. This tool will be</p>	10/10/2012

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	<p>Findings include:</p> <p>Based on review of the Battery Back Up Light Testing documentation on 09/10/12 at 9:15 a.m. with the Maintenance Supervisor present, there was no documentation to show the battery back up light set within the generator housing has been tested monthly for thirty seconds since 06/04/12, furthermore, there was no documentation of a ninety minute annual test within the past twelve months. Based on interview at the time of record review, the Maintenance Supervisor said there was no documentation available to show the battery back up light set within the generator housing had been tested monthly for thirty seconds since 06/04/12, and an annual ninety minute test within the past twelve months. Based on observation at 11:15 a.m. during a tour of the facility with the Maintenance Supervisor, the battery back up light set at the generator did light up when tested.</p> <p>3-1.19(b)</p>		<p>monitored by Administrator monthly and reviewed in quarterly QA to see if any further action is warranted. Completion date 10-10-12</p>		

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K0047 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed with continuous illumination also served by the emergency lighting system in accordance with section 7.10. 18.2.10.1.</p> <p>Based on observation and interview, the facility failed to ensure a continuously illuminated exit sign, where the exit or way to reach the exit was not apparent, was provided over 3 of 5 exit doors from the new dining room and attached east and northwest corridors. LSC 18.2.10.1 refers to 7.10. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not apparent to the occupants. This deficient practice could affect all residents, as well as staff and visitors while exiting the new dining room which has a capacity to seat all residents.</p> <p>Findings include:</p> <p>Based on observations on 09/10/12 between 11:40 a.m. and 12:00 p.m. during a tour of the facility with the Maintenance Supervisor, there were no</p>	K0047	<p>K047 The corrective action taken for those residents found to have been affected by the deficient practice is that no specific residents were identified. The corrective action taken to identify those residents having the potential to be affected by the same deficient practice is that all residents, staff and visitors have the potential to be affected. The corrective action taken for those with the potential to be affected is that an illuminated exit sign has been placed over the northwest attached corridor. After speaking with the inspector it is determined that an illuminated sign over the east doors is not required at this time. The exit signs that were not illuminated over the east & northwest corridor were removed.</p> <p>The measures or systemic changes made to ensure that the deficient practice does not recur is that Maintenance has been in-serviced on the requirement for all required exits to have an illuminated exit sign. The corrective action will be monitored to ensure the deficient practice will not recur is that a Performance Improvement Tool has been implemented. Maintenance will complete this tool weekly times three, monthly</p>	10/10/2012			

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	<p>illuminated exit signs over the two sets of smoke barrier doors from the new dining room to the east and northwest attached corridors, furthermore, there was an exit sign over the outside exit door from the northwest corridor, however, the exit sign was not an illuminated sign. This was acknowledged by the Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b)</p>		<p>times three and quarterly times three quarters. This tool will be monitored by the Administrator. The outcome will be reviewed in quarterly QA meeting to see if further action is warranted.</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. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drills book on 09/10/12 at 8:45 a.m. with the Maintenance Supervisor present, four of four second shift (evening) fire drills since September of 2011 were performed between 2:15 p.m. and 3:00 p.m. During an interview at the time of record review, the Maintenance Supervisor acknowledged the times of the second shift fire drills were not varied.</p>	K0050	<p>K050 The corrective action taken for those residents found to have been affected by the deficient practice is that no specific residents were identified.</p> <p>The corrective action taken to identify those residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected. The corrective action taken for those residents with the potential to be affected is that a second shift fire drill has been conducted on 10-3-12 at 8:00pm.</p> <p>The measures or systemic changes taken to ensure the deficient practice does not recur is that Maintenance has been in-serviced on conducting fire drills at least quarterly on each shift, with a time variance that ensures that such drills are conducted at varying times, (two-three hours apart) each time.</p>	10/10/2012			

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	3-1.19(b)		The corrective action taken to monitor to assure performance and compliance is that a Performance Improvement Tool will be completed by Maintenance monthly. This tool will be reviewed by Administrator. The results of this tool will be reviewed at QA meetings to see if further action is warranted.		

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K0056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.</p> <p>Based on observation and interview, the facility failed to provide an automatic sprinkler system providing complete coverage in 1 of 1 smoke compartments in the new portion of the facility. This deficient practice could affect all residents, as well as staff and visitors while in the new dining room which has a capacity to seat all residents.</p> <p>Findings include:</p> <p>Based on observation on 09/10/12 at 11:45 a.m. during a tour of the facility with the Maintenance Supervisor, the furnace closet within the new dining room did not appear to</p>	K0056	<p>K056</p> <p>The corrective action taken for those residents found to have been affected by the deficient practice is that no specific residents were identified.</p> <p>The corrective action taken to identify those residents is that all residents, staff and visitors have the potential to be affected by the same deficient practice. The corrective action taken for those having the potential to be affected is that the sprinkler devices have been lowered past the duct pipe which runs along the length of the ceiling and is now visible and unobstructed. This now provides complete sprinkler coverage for this area.</p> <p>The measures or systemic changes taken to ensure the deficient practice does not recur is that Maintenance has</p>	10/10/2012			

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	<p>have automatic sprinkler coverage. There were no visible sprinkler heads in the closet. Based on interview at the time of observation, the Maintenance Supervisor said there may be sprinkler head(s) above the large duct pipe which runs along the length of the ceiling, however, this area could not be viewed because of limited space on both sides of the duct pipe. Furthermore, even if there are sprinkler heads above the duct pipe, the closet would not be provided with complete sprinkler coverage due to the blockage of the duct pipe. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>been in-serviced as to the requirement that all smoke compartments in the facility are equipped with an automatic sprinkler system that provides the necessary coverage.</p> <p>The corrective action taken to monitor to assure performance and compliance is that a Performance Improvement Tool has been implemented. This tool will be completed by Maintenance monthly times three months and then quarterly times three quarters. This tool will be monitored by the Administrator and results will be reviewed in quarterly QA meeting to see if further action is warranted.</p>		

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K0144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all</p>	K0144	<p>K144. The corrective action taken for those residents found to have been affected by the deficient practice is that no specific residents were identified. The corrective action taken to identify those residents having the potential to be affected by the same deficient practice is that all residents, staff and visitors have the potential to be affected. The corrective action taken for those residents with the potential to be affected is that Maintenance has conducted a testing of the emergency generator providing power to the emergency light systems. The generator has been exercised under operating conditions of 30 percent of the EPS nameplate rating a minimum of 30 minutes in accordance with NFPA 99. 3.4.4.1 and will be tested for 30 minutes under operating conditions of 30 percent monthly 3.4.4.1 The measures or systemic changes taken to ensure the deficient practice does not recur is that Maintenance has been in-serviced to the requirement of testing the emergency generator providing power to the emergency light systems. Further that the generator will be exercised under operating conditions of 30 percent</p>	10/10/2012

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	<p>residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Generator Log on 09/10/12 at 9:45 a.m. with the Maintenance Supervisor present, the generator log form documented the generator was tested weekly under load, however, there was no documentation on the form that showed the generator was exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes since September of 2011. During an interview at the time of record review, the Maintenance Supervisor confirmed the weekly generator log did not include documentation the generator was exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes.</p> <p>3.1-19(b)</p>		<p>of the EPS nameplate rating a minimum of 30 minutes per month in accordance with NFPA 99 3.4.4.1. Also, the results will be documented and available for inspection. The corrective action taken to monitor to assure performance and compliance is that a Performance Improvement Tool has been implemented to ensure the deficient practice does not recur. This tool will be completed monthly by Maintenance and reviewed by Administrator. The outcome will be reviewed in quarterly QA to see if further action is warranted.</p>		