

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155103	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/12/2014
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NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614
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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 Date: 02/11/14 and 02/12/14</p> <p>Facility Number: 000042 Provider Number: 155103 AIM Number: 100291540</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist, (02/11-12/14); Brett Overmyer, Life Safety Code Specialist, (02/11-12/14) and Liberty Fruth, Life Safety Code Specialist, (02/12/14)</p> <p>At this Life Safety Code survey, Ironwood Health 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 was determined to be of Type V (111) construction and was</p>	K010000	Preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth or facts alleged or conclusions set forth in this Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. Ironwood Health and Rehabilitation Center desires that this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective March 14, 2014.	

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>fully sprinklered with the exception of the rear entrance canopy. The facility has a fire alarm system with smoke detection the corridors, areas open to the corridors, and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 198 with a census of 112 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered except for the rear entrance canopy. All areas providing facility services were sprinklered except for a detached laundry building, maintenance shed and a storage shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/20/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010014 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure materials used as an interior finish in the corridor had a flame spread rating of Class A or Class B in order to protect 20 of 112 residents. LSC 101 10.2.3.2 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development.</p> <p>(a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire.</p> <p>(b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke</p>	K010014	K14The facility does respectfully dispute the findings offered by the survey team and the attached Informal Dispute Resolution (IDR) has been completed. The facility's fire contractor has inspected the 200 Wing porch vinyl siding with wood shingles and has provided documentation to substantiate compliance with current NFPA and Life Safety Code regulations.	02/12/2014			

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	<p>test scale.</p> <p>(c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect any resident on the 200 wing as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility on 02/11/14 from 1:00 p.m. to 3:50 p.m., the 200 wing porch had vinyl siding with wood shingles used as an interior finish. Interview with the Maintenance Director after the time of observation revealed no documentation was immediately available to demonstrate the siding and shingles exhibited a flame spread classification of Class A or B.</p> <p>3.1-19(b)</p>				

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K010018 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. 1. Based on observation and interview, the facility failed to ensure 1 of 200 corridor doors did not have an impediment to closing. This deficient practice could affect any resident as well as staff and visitors using the 400 unit hall.</p> <p>Findings include:</p> <p>Based on observation with the Area Regional Director of Environmental Services during a tour of the facility on 02/12/14 from 9:00 a.m. to 12:00 p.m., the 400 hall MDS office door was propped open with a plastic wedge under the door. Based on interview at the time of observation, the Area Regional Director of Environmental</p>	K010018	<p>K18What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? The plastic wedge that was used to prop-open the door to the MDS office has been removed and the door is no-longer impeded from closing. The pencil-sized hole in the in the 500 hall medical supply door that was located above the door handle, has been repaired; the door does now provide a proper smoke barrier as required. The Maintenance Director has been in-serviced that facility fire doors are to be inspected during routine walking rounds to ensure that no facility fire doors contain holes or aberrations that would prevent smoke penetration barriers. All staff has been in-serviced that no facility doors will be propped</p>	03/14/2014			

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	<p>Services acknowledged the door should not be propped open and wedges were not allowed.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 200 corridor doors were capable of resisting smoke. This deficient practice could affect any resident as well as staff and visitors using the 500 unit hall.</p> <p>Findings include:</p> <p>Based on observation with the Area Regional Director of Environmental Services during a tour of the facility on 02/12/14 from 9:00 a.m. to 12:00 p.m., the 500 hall medical supply closet door had a pencil size hole above the door handle. Based on interview at the time of observation, the Area Regional Director of Environmental Services acknowledged the hole in the door would not resist the passage of smoke.</p> <p>3.1-19(b)</p>		<p>open. The facility Maintenance Director will complete routine walking rounds to ensure that facility doors are not propped open. How other residents having the potential to be affected by the deficient practice will be identified and what corrective action (s) will be taken?All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director will log any identified concerns related to propped fire doors and holes in facility fire doors on the routine rounding log sheets and will follow-up immediately to ensure that compliance is maintained. The Administrator/ Designee will review the completed log sheets on a weekly basis to ensure that needed follow-up has been completed. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?The Administrator/ Designee will, twice per month, complete a walking round with the Maintenance Director to ensure that no facility doors are propped and further to ensure that facility fire doors do-not contain holes or impediments to the fire penetration barriers. How the corrective action (s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place?The rounding logs</p>		

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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 5 of 10 smoke barriers were protected to maintain the smoke resistance of each smoke barrier. 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</p>	K010025	<p>completed by the Maintenance Director that are reviewed weekly by the Administrator/ Designee, will be further reviewed at the regularly scheduled Quality Assurance Committee meeting (QA) for a period of three months, and then quarterly thereafter, to ensure that compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings. Completion Date: March 14, 2014</p> <p>K25What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The Maintenance Director has repaired the exposed penetrations in the attic smoke barriers. The repairs were made in the following locations: The 100 hall smoke barrier near Therapy, the 100 hall smoke barrier near the nurses' station, the two</p>	03/14/2014	

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	<p>smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect at least 100 residents as well as staff and visitors if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility on 02/11/14 from 1:00 p.m. to 3:50 p.m., there were exposed penetrations through the smoke barriers in the attic at the following locations that were not firestopped:</p> <ol style="list-style-type: none"> The 100 hall smoke barrier near Therapy had a three foot by four foot opening through the drywall that was not sealed. The 100 hall smoke barrier near the nurses station had a four inch by four inch opening through the drywall that was not sealed. The smoke barrier separating the main dining room and the front lounge had two penetrations two inches by three inches through the drywall that were not sealed. The 400/500 hall smoke barrier had a two foot by three foot opening through the drywall that was not sealed. The ceiling smoke barrier in the 		<p>penetrations located in the smoke barrier separating the main dining room and the front lounge, the 400/500 hall smoke barrier, the ceiling smoke barrier in the Therapy office, Therapy storage room and the two holes that were located near the old 200 nurses' station. The Maintenance Director has been in-serviced that identified facility exposed penetrations are to be logged on the routine maintenance rounding logs and repaired immediately to ensure that compliance is maintained. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director will log any identified concerns relative to smoke penetration barriers and will immediately repair any identified concerns. The Administrator/ Designee will review the completed logs on a weekly basis to allow for needed follow-up. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? The Corporate Maintenance Director/ Designee will, twice per month, complete a walking round with the Maintenance Director to verify the repair of any identified smoke penetrations. The results of the</p>				

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K010027 SS=C	<p>Therapy office, Therapy storage room and the old 200 nurses station had two inch holes where cable had been run through that were not sealed. Based on interview during the times of observation, the Maintenance Director acknowledged the unprotected openings through the smoke barriers.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 10 of 10 sets of</p>	K010027	<p>rounds will be logged and reviewed in the daily morning meetings to allow for additional follow-up and review by the Interdisciplinary Team. How the corrective action(s) will be monitored to ensue the deficient practice will not recur, i.e., what quality assurance program will be put into place? The routine rounding logs completed by the Maintenance Director, will be reviewed by the Administrator/Designee on a weekly basis. The Quality Assurance Committee (QA) will review the maintenance logs at the regularly scheduled QA meeting for a period of three months and then quarterly thereafter. The QA committee will make recommendations for needed changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings. Completion Date: March 14, 2014</p> <p>K27 What corrective actions will be accomplished for those residents found to have ben</p>	03/14/2014			

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	<p>smoke barrier doors were equipped with the appropriate hardware to ensure the door that must close first, always closes first so that both doors will always close completely as a pair. Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors that swing in the same direction and equipped with an astragal to have a coordinator to ensure the door with the astragal closes over the opposite door. This deficient practice could affect any resident as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility on 02/11/14 from 1:00 p.m. to 3:50 p.m., corridor smoke barrier doors throughout the facility swung in the same direction and were equipped with an astragal but lacked a coordinator to ensure the smoke barrier door without the astragal closed first. Based on interview during the time of observation, the Maintenance Director acknowledged all sets of smoke barrier doors were provided with astragals, swung in the same direction and lacked coordinators.</p> <p>3.1-19(b)</p>		<p>affected by the deficient practice? The 10 facility smoke barriers have been properly equipped with the appropriate hardware to ensure that the door which must close first always closes first; all smoke barrier doors now close completely as a pair. The smoke barrier doors are now equipped with a coordinating device that ensures closure of the doors without the astragal being closed. The Maintenance Director has been in-serviced that all facility smoke -barrier doors are to be checked during routine rounds to ensure that the doors do properly close, and are properly fitted with a coordinating device. How other residents found to have been affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director will complete routine walking rounds in the facility to ensure that facility smoke barrier doors do close properly and that the doors are fitted with a coordinating device. Identified concerns will be placed on a maintenance log and will be repaired immediately. The logs completed by the Maintenance Director will be reviewed by the Administrator/ Designee on a weekly basis to ensure consistent follow-up and regulatory compliance. What measures will</p>		

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			<p>be put into place and what systematic changes will be made to ensure the deficient practice does not recur?The Administrator/ Designee will, twice per month, complete walking rounds with the Maintenance Director to inspect and ensure the proper closing of smoke barrier doors and further to ensure that all smoke barrier doors are properly fitted with the appropriate closure devices. How corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The maintenance logs completed by the Maintenance Director will be reviewed by the Administrator / Designee on a weekly basis. The Quality Assurance Committee (QA) will review the maintenance logs in the regularly scheduled QA meeting for a period of three months and then quarterly thereafter, to ensure that compliance is maintained. The QA committee will make recommendations for needed changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings.</p> <p>Completion Date:March 14, 2014</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 1 of 10 doors serving hazardous areas such as areas larger than 50 square feet storing combustible materials closed and latched to prevent the passage of smoke. This deficient practice could affect 20 residents as well as staff and visitors on the 200 hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility on 02/11/14 from 1:00 p.m. to 3:50 p.m., room 201 lacked a door closer. This room exceeded 50 square feet and was being used for the storage of combustible activity supplies. Based on interview at the time of observation, the Maintenance Director acknowledged the door did not self close and latch to</p>	K010029	<p>K29What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Rm. 201 on the 200 hall in the facility has been fitted with a door closer and the door does now self-close and latch.The Maintenance Director has been in-serviced that facility doors are to be checked on a weekly basis to ensure that the doors to properly latch and further to ensure that the doors are properly fitted with a door closer. 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? All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director will complete a routine walking round in the facility to ensure the proper closures of facility doors and further to</p>	03/14/2014			

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	prevent the passage of smoke. 3.1-19(b)		ensure that facility doors do appropriately latch. Identified concerns will be listed on the maintenance rounding logs and repaired immediately. The Administrator/ Designee will review the completed maintenance logs on a weekly basis to ensure that needed follow-up is completed. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?The Administrator/ Designee will, twice per month, complete a walking round with the Maintenance Director to inspect the proper closures of facility doors and further to ensure that facility doors do properly latch. The results of the rounds will be logged and reviewed in the daily morning meeting to allow for additional follow-up by the Interdisciplinary Team. How corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The maintenance rounds that are completed by the Maintenance Director will be reviewed weekly by the Administrator/ Designee and further reviewed at the regularly scheduled Quality Assurance Meetings (QA) for a period of three months and then quarterly thereafter, to ensure that compliance is maintained. The QA committee will make		

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure not more than one delayed egress lock device complying with NFPA 101 7.2.1.6.1 was provided in any egress path as permitted by NFPA 1011, 19.2.2.2.4, Exception No. 2 in 1 of 13 egress paths. This deficient practice could affect approximately 30 of 112 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility on 02/11/14 from 1:00 p.m. to 3:50 p.m., the Therapy corridor entrance and Therapy exterior exit door were each provided with delayed egress locks with signage. Based on interview during the times of observation, the Maintenance Director acknowledged the two doors were provided with a 15 second delayed egress magnetic lock and were within the same egress path.</p>	K010038	<p>recommendations for needed changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings. Completion Date: March 14, 2014</p> <p>K38What corrective action (s) will be accomplished for those residents found to have affected by the deficient practice?The time delay system on the Therapy Corridor entrance door was removed. The Therapy Corridor exit door has been fitted with a 15 second delay. The adjacent door to the release device has a visible durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. Door can be opened in 15 seconds"The exit doors in the main dining and 500 hall parking lot exits has been repaired and does now have an audible signal and the doors do also properly release when pressure is applied. The Maintenance Director was in-serviced that facility exit doors will be checked on a routine basis for proper working order. The Director will ensure that the all exit doors are affixed with proper signage for 15 second release doors and further that the releasing device does exhibit an</p>	03/14/2014			

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 13 exit doors with a delayed egress lock were readily accessible. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided:</p> <p>(a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6.</p> <p>(b) The doors unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release</p>		<p>audible signal and finally that the exit doors do properly release when pressure is applied. 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? All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director will complete routine walking rounds in the facility to ensure that all facility exit doors are supplied with the proper signage as needed and further to ensure that the exit doors exhibit an audible signal; finally, the Director will ensure that exit doors do properly release when pressure is applied. Identified concerns will be listed on the routine maintenance rounding logs and will be corrected immediately by the Maintenance Director. The Administrator/ Designee will complete a weekly review of the routine maintenance rounding logs to allow for needed follow-up. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? The Administrator / Designee will, twice per month, complete a walking round with the Maintenance Director to ensure that facility exit doors are supplied with proper signage as needed and further to ensure that the exit doors exhibit an audible signal; finally, the Administrator/</p>		

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	<p>device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS".</p> <p>This deficient practice could affect any resident, staff or visitor who use the 500 hall parking lot exit or the main dining room exit.</p> <p>Findings include:</p> <p>Based on observation with the Area Regional Director of Environmental Services during a tour of the facility on 02/12/14 from 9:00 a.m. to 12:00 p.m., the exit doors in the main dining room and the 500 hall parking lot exit were</p>		<p>Designee and the Maintenance Director will ensure that exit doors do properly release when pressure is applied. Identified concerns will be listed on the routine maintenance rounding logs and will be corrected immediately by the Maintenance Director. How corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The routine rounding logs completed by the Maintenance Director and reviewed weekly by the Administrator/ Designee, will further be reviewed at the regularly scheduled Quality Assurance Meetings (QA) for a period of three months, and then quarterly thereafter, to ensure that compliance is maintained. The QA committee will make recommendations for need changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings.</p> <p>Completion Date: March 14, 2014</p>				

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K010046 SS=F	<p>provided with a fifteen second delay with proper signage but when force was applied to the releasing device on the door, an audible signal was not initiated and the doors did not release. Based on interview at the time of observation, the Area Regional Director of Environmental Services acknowledged the doors did not release.</p> <p>3.1-19(b)</p> <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, observation and interview; the facility failed to provide exterior emergency lighting for 13 of 13 exits. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all residents as well as staff and visitors throughout the facility if forced to evacuate.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 02/11/14 from</p>	K010046	K46The facility does respectfully dispute the findings submitted by the survey team and the attached Informal Dispute Resolution (IDR) has been completed. The exterior lighting is connected to the emergency generator and does properly illuminate as required. The electrical contractor has verified the illumination of the lighting of the facility's emergency generator. Documentation will be provided.	02/12/2014

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K010048 SS=C	<p>8:45 a.m. to 10:30 a.m., a section of a document titled "Generator Survey 2013" completed on 02/08/13 did not include exterior lighting on the list of all items on the emergency panel(s). Based on interview during the time of record review with the Maintenance Director, it could not be verified that the exterior lighting was connected to the generator. Based on observation with the Area Regional Director of Environmental Services during a tour of the facility on 02/12/14 from 9:00 a.m. to 12:00 p.m., battery operated powered exterior lights were not provided at the exits.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review, observation and interview; the facility failed to develop a written fire safety plan to address staff response to the activation of battery operated smoke detectors installed in 112 of 112 resident sleeping rooms and the use of portable fire extinguishers.. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall</p>	K010048	<p>K48What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The facility has developed a written fire safety plan that does address the staff response to the activation of battery operated smoke detectors in resident sleeping rooms and the use of portable extinguishers by staff.</p>	03/14/2014			

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	<p>provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Emergency Preparedness Manual" documentation with the Maintenance Director during record review on 02/11/14 from 8:45 a.m. to 10:30 a.m., the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in each of 104 resident sleeping rooms or address the use of portable fire extinguishers including the K-class fire extinguisher. Based on observation with the Area Regional Director of Environmental Services during a tour of the facility on 02/12/14 from 9:00 a.m. to 12:00 p.m., battery operated smoke detectors were installed in each resident sleeping room. Based on interview</p>		<p>The facility's fire safety plan is in compliance with LSC 19.2.2.2 and the plan does detail the proper procedures to follow related to the following: Use of alarms, transmissions of alarms to the fire department, response to alarms, isolation of fires, evacuation of immediate areas, evacuation of smoke compartment, preparation of floors and building for evacuation, and extinguishment of fire. The facility has in-serviced all staff as to the updates to the facility's fire safety plan. 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? All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director will complete monthly in-services as to the facility's fire safety plan and all new employees will additionally be in-serviced during the facility's orientation program. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? The Administrator/ Designee and the Maintenance Director will review the fire safety plan and fire drills on a monthly basis and will further document any concerns identified as to the review of the fire safety plan. The review will be conducted to ensure compliance with current NFPA</p>				

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K010050 SS=C	<p>during record review, the Maintenance Director acknowledged the facility's written fire safety plan did not address the use of portable fire extinguishers, including the K-class fire extinguisher or include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms.</p> <p>3.1-19(a)</p> <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 Based on record review and interview, the facility failed to conduct fire drills at unexpected times in 23 of 27 fire drills. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p>	K010050	<p>regulations.How corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The reviews of the fire safety plan that are completed by the Administrator/ Designee and the Maintenance Director, will be further reviewed by the Quality Assurance C committee (QA) for a period of three months, and then quarterly thereafter, to ensure that compliance is maintained. The QA committee will make recommendations for needed changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings.Completion Date:March 14, 2014</p> <p>K50What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The facility fire drill schedule has been revised by the Maintenance Director. The Director has further been in-serviced by the Corporate</p>	03/14/2014	

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	<p>Findings include:</p> <p>Based on review of fire drill report documentation with the Maintenance Director during record review on 02/11/14 from 8:45 a.m. to 10:30 a.m., the following was noted:</p> <p>a. Five of eight first shift fire drills were conducted between 9:00 a.m. and 10:00 a.m..</p> <p>b. Ten of eleven second shift fire drills were conducted between 2:00 p.m. and 3:00 p.m.</p> <p>c. Four of eight third shift fire drills were conducted between 10:00 p.m. and 11:00 p.m. and four of eight third shift drills were conducted at 5:30 a.m. Based on interview at the time of review, the Maintenance Director acknowledged the fire drills were not held randomly.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>Maintenance Director that fire drills are to be held at unexpected times and under varying conditions, at least quarterly on each shift. The Maintenance Director did in-service all staff that fire drills will be held at random times and on random work shifts and, that all staff persons will be required to respond appropriately to all fire drills. 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? All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director will review the fire drill schedule on a weekly basis to determine if changes are needed to the schedule to allow for the randomness of facility fire drills. The Director will ensure that the needed changes are completed and further that fire drills are randomly held. What measures will be put into place and what systematic changes will be made to ensure the deficient practice does not recur? Twice per month, the Maintenance Director and the Administrator/ Designee, will review the fire drill schedule to ensure that the schedule exhibits randomness and further that changes are immediately completed to ensure random scheduling of facility fire drills. How corrective actions will be monitored to ensure the deficient</p>		

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K010051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 1. Based on observation and interview,	K010051	practice will not recur, i.e., what quality assurance program will be put into place?The fire drill schedules that are reviewed weekly by the Maintenance Director and twice a month by the Administrator/ Designee will be further reviewed in the Quality Assurance Committee Meeting (QA) for a period of three months and then quarterly thereafter, to ensure that compliance is maintained. The QA committee will make recommendations for needed changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings.Completion Date:March 14, 2014. K51What corrective actions will	03/14/2014	

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	<p>the facility failed to ensure there was remote annunciation of the fire alarm system to an approved central station. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation on 02/11/14 at 11:00 a.m. with the Maintenance Director, after the fire alarm system was activated, the signal was not received by the monitoring company. Based on interview at the time of observation, this was verified by the Maintenance Director.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide annunciation for 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all occupants.</p> <p>Findings include:</p>		<p>be accomplished for those residents found to have been affected by the deficient practice? The fire alarm system has been repaired and the fire alarm system is receivable by the monitoring company after activation. The 100 hall nursing station is currently occupied and the fire alarm system is monitored on a 24 hour basis by the facility at the 100 hall location. The smoke detectors located near room #s 415, and 421 and the detector between rooms 424 and 426 have been relocated and are now properly separated from all air supply and return vents in accordance with NFPA 72, 2-3.5.1. The Maintenance Director was in- serviced as to the provisions of NFPA 72, 2-3.5.1 and was further in- serviced that the Director will ensure that on a quarterly basis, through the use of the facility's Fire Safety Contractor, that the location of smoke detectors are within proper separation of all air supply and return vents. How other residents having the potential to be affected by the deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by the alleged deficient practice. The facility will ensure that the fire alarm panel is monitored by staff on a 24 hour basis. The Maintenance Director and the facility's Fire Safety Contractor</p>		

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	<p>Based on observation with the Maintenance Director on 02/11/14 from 10:30 a.m. to 11:45 a.m., the fire alarm control panel (FACP) is located in the 100 hall mechanical room and FACP annunciators were located at the 100 hall nurses station and at the main entrance. Based on interview with the Maintenance Director at the time of observation, the 100 hall nurses station is currently unoccupied and has been closed for three months due to lack of census and based on interview with the receptionist on 02/12/14 at 11:45 a.m., the front desk is not occupied after 5:00 p.m.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 3 of 6 smoke detectors located on the 400 hall and connected to the fire alarm system was properly separated from an air supply or return vent. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect at least 10 residents as well as staff and visitors on the 400 hall.</p> <p>Findings include:</p>		<p>will complete a detailed report which will indicate concerns relative to the location of the facility's smoke detectors. All concerns identified will be corrected immediately. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur?The Administrator/ Designee and the Maintenance Director will review the reports of the Fire Safety Contractor on a quarterly basis to ensure that compliance is maintained. The facility staff will be in -serviced on a monthly basis by the Maintenance Director concerning the proper monitoring activity that must occur to ensure proper monitoring of the fire alarm panel on a 24 hour basis. The Administrator/ Designee will review the fire panel monitoring in-services on a quarterly basis. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The fire safety inspections completed by the Fire Safety Contractor and the fire panel monitoring in-services that are reviewed by the Administrator/ Designee and the Maintenance Director on a quarterly basis, will be further reviewed in the Quality Assurance Committee Meeting (QA) for a period of three months, and then quarterly thereafter, to ensure</p>				

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	<p>Based on observation with the Area Regional Director of Environmental Services during a tour of the facility on 02/12/14 from 9:00 a.m. to 12:00 p.m., the following was noted:</p> <p>a. A smoke detector located near room 415 was one foot from an air return vent.</p> <p>b. A smoke detector located near room 421 was one foot from an air supply vent.</p> <p>c. A smoke detector between rooms 424 and 426 was two feet from an air supply vent.</p> <p>Based on interview at the time of observation, the Area Regional Director of Environmental Services acknowledged the distance between the vent and agreed the air flow could interfere with smoke detector function.</p> <p>3.1-19(b)</p>		<p>that compliance is maintained. The QA committee will make recommendations for needed changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings. Completion Date: March 14, 2014</p>		

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K010056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, Section 5-1.1 states sprinklers shall be installed throughout the premises. NFPA 13, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding four feet in width. NFPA 13, 6-1.1.5 requires sprinkler piping or hangers shall not be used to support nonsystem components. NFPA 13, 5-6.3.3 requires sprinklers be located a minimum of 4 inches from a wall. This deficient practice could affect any number of residents, staff and visitors</p>	K010056	<p>K56 What corrective action (s) will be accomplished for those resident found to have been affected by the deficient practice? The rear entrance canopy currently has sprinkler protectionThe sprinkler pipe in the small conference room no longer supports four conduitsThe sprinkler pipe in the Human Resources closet is no longer used to support conduitThe sprinkler pipe in the Business Office is no longer used to support wiringThe sprinkler pipe in the large conference room is no longer used to support cablesThe sprinkler pipe in the Nutritional Services Office is no longer used to support cablesThe sprinkler pipe in the 300 wing storage closet is no longer used to support cablesThe sprinkler heads in the 400 hall dining room above the hand wash sink and</p>	03/14/2014			

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	<p>throughout the facility.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director from 10:30 a.m. to 11:45 a.m. and 1:00 p.m. to 3:45 p.m. on 02/11/14 and with the Area Regional Director of Environmental Services during a tour of the facility on 02/12/14 from 9:00 a.m. to 12:00 p.m., the following was noted:</p> <p>a. The rear entrance canopy lacked sprinkler protection. Based on interview at the time of observation, the Maintenance Director acknowledged the canopy was constructed of wood and exceeded four feet in width and lacked sprinkler protection.</p> <p>b. A section of sprinkler pipe in the small conference room was used to support four conduits.</p> <p>c. A section of sprinkler pipe in the Human Resources closet was used to support conduit.</p> <p>d. A section of sprinkler pipe in the Business office was used to support wiring.</p> <p>e. A section of sprinkler pipe in the large conference room was used to support cables.</p> <p>f. A section of sprinkler pipe in the nutritional services office was used to support cables.</p>		<p>the one sprinkler head in Rm. 411 in addition to the two sprinkler heads in the Ancillary room are no longer situated less than 4 inches from the wall area and the sprinkler pipe has been corrected as to be compliant with NFPA 13, 5-6.3.3. The Maintenance Director was in-serviced that the walking rounds completed by Fire Safety Contractors will be reviewed and further the Director will ensure that the facility remains compliant as to NFPA regulations for sprinkler pipes and sprinkler heads. 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? All residents have the potential to be affected by the alleged deficient practice. The Fire Safety Contractor will complete walking rounds in the facility on a quarterly basis to ensure that sprinkler pipes are-not used to support conduit, wiring, cables and further to ensure that sprinkler heads are at least four inches from facility walls in accordance with NFPA 13, 5-6.3.3. Identified concerns will be documented and corrected immediately. What measures will be put into place and what systematic changes will be made to ensure the deficient practice does not recur? The Maintenance Director will review the walking rounds completed by the Fire</p>		

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	<p>g. A section of sprinkler pipe in the 300 wing storage closet was used to support cables.</p> <p>h. A sprinkler head in the 400 hall dining room above the handwash sink was less than four inches from the wall.</p> <p>i. One of three sprinkler heads in room 411 was less than four inches from the wall.</p> <p>j. Two of four sprinkler heads in the Ancillary room were less than four inches from the wall.</p> <p>Based on interview during the times of observation, the Maintenance Director and Area Regional Director of Environmental Services acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p>		<p>Safety Contractor on a quarterly basis and will further ensure that facility sprinkler pipes and sprinkler heads are in compliance with NFPA 13, 5-6.3.3. Concerns identified by the Fire Safety Contractor will be verified and ensured of correction by the Maintenance Director. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur? The Administrator/ designee will meet with the Maintenance Director on a quarterly basis and will review the reports completed by the Fire Safety Contractor to ensure that regulatory compliance is maintained. How corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The walking rounds completed by the Fire safety Contractor that are reviewed by the Maintenance Director and the Administrator / Designee on a quarterly basis, will further be reviewed in the Quality Assurance Committee Meetings (QA) for a period of three months, and then quarterly thereafter, to ensure that compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings. Completion Date: March 14, 2014</p>		

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K010062 SS=C	<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 1 of 1 sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and patients.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility on 02/11/14 from 1:00 p.m. to 3:50 p.m., the sprinkler system located in the sprinkler riser room had five pressure gauges with 12/03/08 written on the gauges. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p>	K010062	<p>K62What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The gauges on the sprinkler system located in the sprinkler riser room have been replaced. The Maintenance Director has been in –serviced by the Corporate Maintenance Director that all gauges on sprinkler systems are to be maintained in accordance to NFPA regulations. 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?All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director will complete routine walking rounds in the facility to ensure that gauges on sprinkler systems meet current fire safety regulations in accordance to NFPA regulations. Identified concerns will be documented on rounding logs and corrected immediately. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur?The Administrator/ Designee will meet</p>	03/14/2014			

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K010064 SS=E	3.1-19(b) 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 1) Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguishers was adequately protected from physical damage. NFPA 10, 1998 Edition, Standard for Portable Fire Extinguishers, Section 1-6.9 requires fire extinguishers installed under conditions where they are subject to	K010064	with the Maintenance Director on a weekly basis to review the fire safety rounding logs and to ensure that regulatory compliance is maintained. How corrective action (s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place? The routine Fire Safety rounding logs completed by the Maintenance Director will be reviewed by the Administrator/ Designee on a weekly basis and will further be reviewed by the Quality Assurance Committee (QA) for a period of three months and then quarterly thereafter, to ensure that compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings. Completion Date: March 14, 2014 K64 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The K class portable fire extinguisher in the kitchen that contained dents has been replaced by a new K class extinguisher. The extinguisher is also situated as to be protected from physical damage. The	03/14/2014	

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	<p>physical damage, (e.g., from impact, vibration, the environment) shall be adequately protected. This deficient practice would not directly affect residents but could affect and staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Area Regional Director of Environmental Services during a tour of the facility on 02/12/14 from 9:00 a.m. to 12:00 p.m., the K-class portable fire extinguisher had two large dents in the bottom of the extinguisher Based on interview at the time of observation, the Area Regional Director of Environmental Services acknowledged the damage but did not know how long ago the damage occurred and did not know if it would affect the operation of the fire extinguisher.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to inspect 1 of 1 portable fire extinguishers in the Beauty Shop each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the</p>		<p>portable fire extinguisher in the beauty shop has been inspected by the Maintenance Director and the extinguisher does meet with NFPA regulations.The Maintenance Director was in-serviced that walking rounds must be completed on a routine basis to verify that fire extinguishers are in good repair and further to ensure that fire extinguishers are inspected on a monthly basis and are protected from physical damage. How other residents having the potential to be affected by the same deficient practice will be identified?All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director will complete routine walking rounds in the facility to ascertain that all facility fire extinguishers are inspected on a monthly basis and that the extinguishers are in good repair and are protected from physical damage in accordance with NFPA regulations. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?The Administrator/ Designee will meet with the Maintenance Director on a weekly basis to review the fire safety rounding logs and to ensure that regulatory compliance is maintained.How corrective action (s) will be monitored to ensure the deficient practice does not recur, i.e., what quality</p>		

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	<p>person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect any resident using the Beauty Shop.</p> <p>Findings include:</p> <p>Based on observation with the Area Regional Director of Environmental Services during a tour of the facility on 02/12/14 from 9:00 a.m. to 12:00 p.m., the monthly inspection tag on the fire extinguisher located in the Beauty Shop lacked documentation of a monthly inspection for all months since the Annual Inspection which occurred in February of 2013. This was acknowledged by the Area Regional Director of Environmental Services at the time of observation.</p> <p>3.1-19(b)</p>		<p>assurance program will be put into place?The daily fire safety rounding logs completed by the Maintenance Director will be reviewed by the Administrator/ Designee on a weekly basis and further will be reviewed by the Quality Assurance Committee (QA) for a period of three months and then quarterly thereafter, until regulatory compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings. Completion Date: March 14, 2014</p>				

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K010069 SS=B	<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 and interview; the facility failed to ensure 1 of 1 range hood's fire extinguishing equipment was inspected and approved every 6 months by properly trained and qualified persons. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, in 8-2 requires the inspection and servicing of the fire extinguishing system and listed exhaust hoods containing a constant or fire actuated water system shall be made at least every 6 months by properly trained and qualified persons. NFPA 96, 8-2.1 requires all actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, and fire actuated dampers shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice could affect mostly staff during time in the kitchen plus any of the residents during time spent in the Main Dining Room which was in the same smoke compartment as the kitchen.</p> <p>Findings include:</p>	K010069	<p>K69What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The Range Hood suppression system in the kitchen has been inspected in accordance with 9.2.3 19.3.2.6, NFPA 96. The suppression system does meet with current regulatory compliance standards. The Maintenance Director has been in-serviced that the range hood suppression system is to be inspected on an every six month basis by the facility's Fire Safety Contractor. 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? All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director will maintain an on-going log which will detail, every six months, the last inspection date for the Hood suppression system. The Director will ensure that inspections are in accordance to regulatory compliance. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? The Administrator / Designee will</p>	03/14/2014

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K010070 SS=E	<p>Based on review of the facility's range hood suppression system inspection documentation on 02/11/14 from 8:45 a.m. to 10:30 a.m. with the Maintenance Director, the most recent range hood fire extinguishing equipment inspection report was dated 11/14/13 and the previous range hood fire extinguishing equipment inspection report was dated 02/13/13 which covered a period of nine months. Based on interview at the time of record review, the Maintenance Director acknowledged the period of time between the most recent and previous range hood suppression system inspection exceeded six months.</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 Based on observation and interview, the</p>	K010070	<p>meet with the Maintenance Director on a weekly basis to review all facility fire safety systems and to further ensure that regulatory compliance is maintained. The Administrator/ Designee will further review the inspections for the maintenance of the Hood-suppression system every six month to verify that inspections have been completed. How corrective actions will be monitored to ensure the deficient practice will not recur, i. e., what quality assurance program will be put into place?The maintenance logs completed by the Maintenance Director that are reviewed by the Administrator/ Designee on a weekly and every six months basis, will be further reviewed in the Quality Assurance Committee meeting for a period of one year to ensure that regulatory compliance is maintained. The QA committee will make recommendations for needed changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings.Completion Date: March 14, 2014</p> <p>K70What corrective action (s) will</p>	03/14/2014			

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	<p>facility failed to enforce it's space heater policy for the use of 4 of 4 portable space heaters in the facility in accordance with NFPA 101, Section 19.7.8. This deficient practice could affect any number of residents, staff and visitors throughout the facility.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director from 10:30 a.m. to 11:45 a.m. and 1:00 p.m. to 3:45 p.m. on 02/11/14 and with the Area Regional Director of Environmental Services during a tour of the facility on 02/12/14 from 9:00 a.m. to 12:00 p.m., the following was noted:</p> <p>a. A space heater was observed not plugged into a power source in the Therapy office.</p> <p>b. A space heater was observed plugged into a power source and operating in the 500 hall MDS office.</p> <p>c. A space heater was observed plugged into a power source but not operating in the Beauty Shop.</p> <p>d. A space heater was observed plugged into a power source and operating in the Ancillary office. Based on interview at the times of observation, the Maintenance Director and the Area Regional Director of Environmental Services acknowledged the</p>		<p>be accomplished for those residents found to have been affected by the deficient practice? The space heaters in the Therapy Office, 500 hall MDS office, Beauty Shop, and in the Ancillary Office were removed and are no-longer operational in the facility. All staff has been in-serviced by the Maintenance Director that space heaters are-not allowed in the facility and further that any staff person who violates this policy will be appropriately disciplined. 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? All residents have the potential to be affected by the alleged deficient practice. During the routine walking rounds, the Maintenance Director will inspect locations throughout the facility; including office locations. The rounds will be completed on an on-going basis to enforce the facility policy concerning the prohibition of space heaters. Identified concerns will be immediately reported to the Administrator. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? The Administrator / Designee will complete rounds with the Maintenance Director on a weekly basis to ensure that compliance</p>	

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K010072 SS=E	<p>aforementioned conditions and acknowledged the facility does not allow the use of space heaters in the facility.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of impediments to full instant use in the case of fire or other emergency for 1 of 13 exits. This deficient practice could affect at least 15 residents as well as staff and visitors in the Alzheimer unit.</p> <p>Findings include:</p>	K010072	<p>is maintained. How corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The Interdisciplinary Team (IDT) will complete inspections of all facility locations and will complete reports that will be reviewed in the daily morning meetings which will detail the presence and/or absence of space heaters in the facility. The IDT will complete routine inspections for six months until regulatory compliance is maintained. The IDT will further make recommendations for needed follow-up and review. Completion Date:March 14, 2014</p> <p>K72What corrective actions will be accomplished for those residents found to have been affected by the same deficient practice?The snow that was observed in the exit path from the Alzheimer east exit has been removed and the exit remains free of any obstruction that would impede exit from the location.The Maintenance Director has been in-serviced that all exit doors and</p>	03/14/2014	

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	<p>Based on observation with the Maintenance Director during a tour of the facility on 02/11/14 from 1:00 p.m. to 3:50 p.m., the exit path from the Alzheimer east exit was covered with snow. Based on interview at the time of observation, the Maintenance Director acknowledged the exit path from the Alzheimer east exit was snow covered.</p> <p>3.1-19(b)</p>		<p>exit corridors are to remain free of any obstructions that would prevent the free exit of personnel through an exit path. How other residents having the potential to be affected by the deficient practice will be identified and what corrective action (s) will be taken? All residents have the potential to be affected by the alleged deficient practice. Exit pathways will be checked by the Maintenance Director during the completion of routine maintenance rounds by the Director. Identified concerns will be documented and followed-up immediately, to ensure that compliance is maintained. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? The Administrator / Designee will review the maintenance logs completed by the Maintenance Director on a weekly basis to further ensure that regulatory compliance is maintained. How corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The performance maintenance rounds that are completed by the Maintenance Director and reviewed weekly by the Administrator / Designee will further be reviewed at the regularly scheduled Quality Assurance Committee Meeting (QA) for a period of three months</p>		

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K010074 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 2 of 200 rooms were flame retardant. This deficient practice could affect at least 4 residents, staff and visitors in the 400 hall lounge.</p> <p>Findings include: Based on observation with the Area</p>	K010074	<p>and then quarterly thereafter, to ensure that compliance is maintained. The QA committee will make recommendations for needed changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings. Completion Date:March 14, 2014</p> <p>K74What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? The window curtain in the 400 day room lounge was removed and the blanket in the Medical Records Office was also removed.All staff has been in-serviced that objects will not be allowed to hang about facility windows without the prior</p>	03/14/2014	

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	<p>Regional Director of Environmental Services during a tour of the facility on 02/12/14 from 9:00 a.m. to 12:00 p.m., the following was noted:</p> <p>a. Window curtains in the 400 dayroom lounge lacked attached documentation they were inherently flame retardant.</p> <p>b. A blanket being used as a window curtain in the Medical Records office lacked attached documentation it was inherently flame retardant.</p> <p>Based on interview at the time of observation with the Area Regional Director of Environmental Services, there was no documentation regarding flame retardancy for these window curtains available for review.</p> <p>3.1-19(b)</p>		<p>approval of the Administrator and/or the Maintenance Director. 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?All residents have the potential to be affected by the alleged deficient practice. The routine rounds completed by the Maintenance Director will involve a check of facility windows to ensure that objects will not be hung about facility windows without the prior approval of the Maintenance Director and/or Administrator. Identified concerns will be documented on rounding logs and corrected immediately. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?The Administrator / Designee will review the rounding logs completed by the Maintenance Director on a weekly basis to ensure that regulatory compliance is maintained.How corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The rounding logs completed by the Maintenance Director will be reviewed by the Interdisciplinary Team in the daily morning meetings. The IDT will review the Maintenance logs for a period of four months and then quarterly thereafter, and will make</p>		

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K010075 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area for 1 of 104 resident rooms. This deficient practice could affect at least 10 residents as well as staff and visitors on the 500 hall.</p> <p>Findings include:</p> <p>Based on observation with the Area Regional Director of Environmental Services during a tour of the facility on 02/12/14 from 9:00 a.m. to 12:00 p.m., one 28 gallon container of biohazardous soiled linen and one 28 gallon container of biohazardous trash were adjacent to</p>	K010075	<p>recommendations for needed follow-up and review to ensure that regulatory compliance is maintained. Completion Date: March 14, 2014</p> <p>K75What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The two 28 gallon containers for trash and for linen were removed. The Nursing staff, Housekeeping staff and Maintenance staff were in-serviced that only one 28 gallon container for trash would be used in resident rooms for residents that have been appropriately isolated. Resident soiled linens for isolated residents will be handled in accordance to universal precautions. 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? All residents have the potential to be affected by the alleged deficient practice. The Director of</p>	03/14/2014			

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	<p>one another in resident room 512. Based on an interview at the time of observation, the 500 hall Unit Manger confirmed the containers were used for biohazardous waste and linen.</p> <p>3.1-19(b)</p>		<p>Housekeeping and/or Designee, will complete walking rounds on a routine basis to ensure that trash containers in excess of 28 gallons are-not utilized in resident rooms for facility residents that are isolated. Identified non-compliance will be documented, corrected immediately and reported to the Administrator for follow-up as needed. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? The Administrator / Designee will review the rounding logs completed by the Housekeeping Director on a weekly basis to ensure that regulatory compliance is maintained. The Administrator will ensure that additional training and in-servicing of staff is scheduled as needed. How corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The routine walking rounds completed by the Housekeeping Director that are reviewed by the Administrator/ designee on a weekly basis, will additionally be reviewed by the Interdisciplinary Team (IDT) at the daily morning meetings, and then quarterly thereafter.. The IDT will make recommendations for needed follow-up and review to ensure that regulatory compliance is maintained.</p>		

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K010130 SS=C	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 104 of 104 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of documentation with the Maintenance Director on 02/12/14 at 2:00 p.m., the facility has a preventative maintenance program for battery operated smoke detectors but the documentation did not give specific locations of resident rooms that were checked. Based on interview at the time of review, the Maintenance Director acknowledged the battery operated smoke detectors are randomly checked and locations listed as 100 hall, 200 hall, 300 hall, 400 hall and 500 hall.</p> <p>3.1-19(a)</p>	K010130	<p>Completion Date: March 14, 2014</p> <p>K130 What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? The water heater in the 100 hall mechanical room has been inspected and does currently contain a State of Indiana Certificate of Inspection which does ensure the safe operating condition of the boiler. The facility did create new templates which accurately detail where the facility's battery operated smoke detectors are located in resident rooms and throughout the facility. The detectors are inspected on a weekly basis and the Maintenance Director does properly document the location, date and operability of each detector. The Maintenance Director has been in-serviced that facility boiler systems will be inspected in accordance with standard operating procedures and further that the facility boilers will be affixed at all times, with a current Certificate of Inspection from the State of Indiana. The Director was additionally in serviced that all facility battery operated smoke detectors will be inspected on a weekly basis and that the inspections of the detectors will detail the location, date and operability of each smoke detector. How other</p>	03/14/2014			

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	<p>2. Based on record review and interview, the facility failed to ensure 1 of 5 water heaters had a State of Indiana Certificate of Inspection to ensure the boiler was in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of the blue metal tag attached to the water heater in the 100 hall mechanical room with the Maintenance Director on 02/11/14 from 10:30 a.m. to 11:45 a.m., there was not a matching Indiana Certificate of Inspection available. Based on interview at the time of observation, the Maintenance Director did not know where the certificate was located.</p> <p>3.1-19(b)</p>		<p>residents having the potential to be affected by the deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director will complete a log of inspections on a weekly basis. Identified concerns will be documented and corrected immediately. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? The Administrator/ Designee will review the rounding logs completed by the Maintenance Director on a weekly basis to ensure that regulatory compliance is maintained. Once a month, the Administrator/ Designee will round with the Maintenance Director to ensure compliance and follow-up. How corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The rounding logs completed by the Maintenance Director that are reviewed weekly and monthly by the Administrator/ Designee will further be reviewed by the Quality Assurance Committee (QA) for a period of three months, and then quarterly thereafter, until regulatory compliance is maintained. The QA Committee will make recommendations for needed</p>		

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K010144 SS=F	<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>1. Based on observation and interview, the facility failed to ensure 1 of 1 generators were in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. This deficient practice could affect all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 02/11/14 from 10:30 a.m. to 11:45 a.m., the generator remote annunciator panel is located at the 100 hall nurses station. Based on interview with the Maintenance Director at the time of observation, the 100 hall nurses station is currently unoccupied and has been closed for three months due to lack of census.</p> <p>3.1-19(b)</p>	K010144	<p>changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings.</p> <p>K144What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? The 100 hall nursing station is currently occupied and the remote annunciator is readily observed by operating personnel at their regular work station. The Emergency Generator is currently exercised in accordance with NFPA 110, Chapter 6-4.2 and all Emergency Generator load testing is properly documented. The Maintenance Director has been in-serviced that the Emergency Generator will be tested with a load on a monthly basis and further that the Generator will be exercised for a period of 30 minutes with each load testing and finally that all Emergency Generator load testing will be properly documented. The facility staff has been in-serviced and will be further in-serviced on a monthly basis by the Maintenance Director concerning proper monitoring activity that must occur to ensure that monitoring of the fire alarm panel is on a 24 hour basis. How other</p>	03/14/2014	

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	<p>2. Based on record review and interview, the facility failed to exercise the generator for 2 of 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p>		<p>residents having the potential to be affected by the deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director will complete rounding logs on a weekly basis to ensure that the facility's annunciator panel is properly monitored and that proper testing of the Emergency generator under load condition does occur. The operating condition of the Emergency Generator will be documented and any identified concerns will be corrected Immediately..</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? The Administrator/ Designee will review the rounding logs completed by the Maintenance Director on a weekly basis to ensure that regulatory compliance is maintained. The Administrator / Designee will additionally complete a monthly round with the Maintenance Director to ensure that the facility's Emergency Generator is properly tested and further to ensure that the facility's annunciator panel is properly monitored by staff.</p> <p>How corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place? The weekly</p>		

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K010147 SS=E	<p>Based on review of "Emergency Generator Log: Monthly with a Load" documentation with the Maintenance Director during record review on 02/11/14 from 8:45 a.m. to 10:30 a.m., monthly generator load tests were not documented for March and April of 2013. Based on interview at the time of record review, the Maintenance Director acknowledged documentation for monthly load testing for March and April of 2013 was not available for review.</p> <p>3.1-19(b)</p> <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 extension cords including powerstrips and non-fused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and</p>	K010147	<p>rounding logs completed by the Maintenance Director that are reviewed weekly and monthly by the Administrator/Designee, will further be reviewed by the Quality Assurance Committee (QA) for a period of three months, and then quarterly thereafter, until regulatory compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings. Completion Date:March 14, 2014</p> <p>K147What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? The refrigerator plugged into a power strip which was plugged into another power strip in the admissions office is no longer plugged into any power stripsThe refrigerator on the 200 hall nurses' station is no longer plugged into a power stripThe television and radio that were plugged into a multi-plug adaptor in resident room # 207 are no</p>	03/14/2014	

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NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614		
(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	
	<p>cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect least 50 residents, staff and visitors throughout the facility.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director from 10:30 a.m. to 11:45 a.m. and 1:00 p.m. to 3:45 p.m. on 02/11/14 and with the Area Regional Director of Environmental Services during a tour of the facility on 02/12/14 from 9:00 a.m. to 12:00 p.m., the following was noted:</p> <p>a. A refrigerator was plugged into a power strip which was plugged into another power strip in the Admissions office.</p> <p>b. A refrigerator was plugged into a power strip in the 200 hall nurses station.</p> <p>c. A television and radio were plugged into a multiplug adapter in resident room 207.</p> <p>d. An oxygen concentrator and nebulizer were plugged into a power strip in resident room 417.</p> <p>e. A refrigerator was plugged into a power strip in resident room 427.</p> <p>f. A refrigerator was plugged into a power strip in resident room 511.</p> <p>g. A refrigerator was plugged into a</p>		<p>longer plugged in to the multi plugged adaptorThe oxygen concentrator, refrigerator, and nebulizer in Resident Rm. # 427 are no longer plugged into power strips.The refrigerator s in rms. 511 and 516, are no longer plugged into a power stripsThe microwave is no longer plugged into a power strip in the Employee Break roomThe oxygen concentrator, refrigerator and bed in resident rm. # 302, are no longer plugged into a power strip.The computer on the 300 hall nurses' station is no longer plugged into a multi plug adaptorThe junction boxes below the overbed light fixtures in Rms. 505, 518 and 526 have been covered.The 500 hall electrical room is no longer used as storage and the room does now have three feet of clearance in front of electrical panels. How other residents having the potential to be affected by the deficient practice will be identified and what corrective actions will be taken?All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director was in-serviced that all areas of the facility will be checked on a weekly basis to ensure that no medical equipment or electrical appliances are plugged into power strips and/or are plugged into multi-plugged adaptors that are plugged into power strips. The Director was further</p>		

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	<p>power strip in resident room 516.</p> <p>h. A microwave was plugged into a power strip in the Employee Break room.</p> <p>i. An oxygen concentrator, refrigerator and bed were plugged into a power strip in resident room 302.</p> <p>j. A computer was plugged into a multiplug adapter at the 300 hall nurses station.</p> <p>Based on interview at the time of observation, the Maintenance Director and Area Regional Director of Environmental Services acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure electrical wiring connections were maintained in a safe operating condition which includes junction boxes in 3 of 104 resident rooms. 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 10 or more residents, staff and visitors on the 500 hall.</p> <p>Findings include:</p> <p>Based on observation with the Area</p>		<p>in-serviced that electrical rooms will not contain storage and that all electrical panels will have a three feet clearance in front of the panels to allow for easy access. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur?The Maintenance Director will complete a rounding log on a weekly basis that will detail the condition of electrical rooms and/or the presence or absence of power strips and adaptors throughout the facility. Identified concerns will be logged and corrected immediately. The Administrator/ Designee will, on a weekly basis, review the weekly logs completed by the Maintenance Director and will ensure that regulatory compliance is maintained. The Administrator/Designee will additionally complete monthly rounds with the Maintenance Director to ensure that compliance is maintained. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?The rounding logs completed by the Maintenance Director that are reviewed by the Administrator on a weekly and monthly basis, will be further reviewed by the Quality assurance Committee (QA) at the regularly scheduled QA meetings for a period of three months, and</p>				

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	<p>Regional Director of Environmental Services during a tour of the facility on 02/12/14 from 9:00 a.m. to 12:00 p.m., junction boxes below the overbed light fixtures were left uncovered in rooms 505, 518 and 526. The Area Regional Director of Environmental Services acknowledged at the time of observation, the boxes should have had covers secured over the uncovered boxes.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure sufficient access and working space for 1 of 5 electrical rooms was provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment in accordance with NFPA 70, Article 110-26 which requires a minimum of three feet of clearance. This deficient practice could affect any resident, staff and visitors on the 500 hall.</p> <p>Findings include:</p> <p>Based on observation with the Area Regional Director of Environmental Services during a tour of the facility on 02/12/14 from 9:00 a.m. to 12:00 p.m., the 500 hall electrical room was being</p>		<p>then quarterly thereafter. The QA Committee will make recommendations for needed changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings. Completion Date: March 14, 2014</p>		

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	<p>used for storage and lacked at least three feet of clearance in front of the electrical panels. Based on interview at the time of observation, the Area Regional Director of Environmental Services acknowledged the room was being used for storage, limiting access to the electrical equipment.</p> <p>3.1-19(b)</p>			