

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/16/2011
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NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011
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K0000	<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: 12/16/11</p> <p>Facility Number: 000005 Provider Number: 155005 AIM Number: 100270840</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Manorcare Health Services 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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 216 and had a census of 136 at the time of this survey.</p>	K0000	<p>January 16, 2012</p> <p>Long Term Care Division, 4 th Floor 2 North Meridian Street Indianapolis, IN 46204</p> <p>RE: ManorCare Health Services of Anderson 1345 N. Madison Ave. Anderson, IN 46011</p> <p>Dear Kim Rhoades:</p> <p>Please note our Plan of Correction and allegation of compliance for the Annual Life Safety Code Survey completed on December 16, 2011.</p> <p>Should you have any other questions or need additional information, please contact me at the above address or phone number. You may also contact me via email at 421admin@hcr-manorcare.com.</p> <p>Sincerely,</p> <p>Nicole Fields, HFA Administrator</p>	

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

TITLE

(X6) DATE

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

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K0018 SS=E	<p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/05/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>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. Based on observation and interview, the facility failed to ensure corridor doors for 1 of 2 Dining room doors on Intermediate hall, 1 of 1 Supply closet doors on Medicare front hall and 1 of 1 Employee lounge doors on Main hall would latch into their frame. This deficient practice could affect 17 residents on Intermediate hall north, 8 residents on Medicare front hall and 11 residents on Intermediate hall</p>	K0018	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>The doors to the employee breakroom, intermediate lounge and the medicare front hall supply closet were repaired.</p> <p><b>How other residents having the</b></p>	01/17/2012

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	<p>northwest which is adjacent to Main hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 12/16/11 during the tour between 11:00 a.m. and 1:20 p.m. with the Maintenance Supervisor, the following corridor doors would not latch into their frames:</p> <p>a. The west corridor door leading into the Dining room on Intermediate hall,</p> <p>b. The Supply closet corridor door on Medicare front hall,</p> <p>c. The Employee lounge corridor door on Main hall.</p> <p>Based on interview on 12/16/11 concurrent with each observation with the Maintenance Supervisor, it was acknowledged the aforementioned doors would not latch into their frames.</p> <p>3.1-19(b)</p>		<p><b>potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>All doors were evaluated for proper functioning and identified deficiencies were corrected.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>Maintenance Director or designee will perform monthly audits to ensure proper door function.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</b></p> <p>Audit findings will be presented to QA&amp;A committee monthly for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring per the QA&amp;A process.</p>		

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K0025 SS=E	<p>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 2 of 4 smoke barrier walls on Medicare unit were protected to maintain the one half hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire be protected, so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 25 residents on Medicare unit as well as visitors and staff if smoke from a fire were to infiltrate the protective barrier wall.</p> <p>Findings include:</p> <p>Based on observations on 12/16/11 between 2:30 p.m. and 2:50 p.m. with the Maintenance Supervisor, the following</p>	K0025	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Two identified smoke barriers on the Medicare Unit were repaired.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>All penetrations evaluated for compliance per Life Safety Code and identified deficiencies were corrected.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>Maintenance Director or designee will perform monthly firewall inspections to ensure compliance</p>	01/17/2012			

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	<p>exposed penetrations in the smoke barrier walls were not firestopped or sealed with a fire rated material:</p> <p>a. Center hall west on Medicare unit next to laundry had a three inch by six inch opening at the top center of the smoke wall which was not not firestopped,</p> <p>b. Medicare front hall smoke barrier wall had a one half inch diameter metal conduit penetrating the wall to the upper left with a one half inch gap around the pipe which was not firestopped.</p> <p>Based on interview on 12/16/11 concurrent with each observation with the Maintenance Supervisor, it was acknowledged the aforementioned smoke barrier walls had unprotected openings which were not sealed with a fire rated material.</p> <p>3.1-19(b)</p>		<p>with Life Safety Code.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</b></p> <p>Audit findings will be presented to QA&amp;A committee monthly for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring per the QA&amp;A process.</p>		

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K0029 SS=E	<p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 8 doors leading to hazardous areas such as rooms with combustibile items were provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 8 residents on Intermediate unit and 21 residents on Family tree South hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 12/16/11 between 12:59 p.m. to 1:45 p.m. with the Maintenance Supervisor, the Clean utility storage room on Intermediate east hall had twenty cardboard boxes stored inside and the Storage room on Family tree south had forty two cardboard boxes stored inside it. Both rooms were greater than fifty square feet and were without a self closing device on each corridor door.</p>	K0029	<p>*Addendum Response* <b>K-29</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Door closers will be installed on the identified doors on the Intermediate and Family Tree unit.</p> <p>Regarding the metal rolling doors separating the kitchen from the corridor, the fusable link and cables were reattached and the door closure reset. A relay module was installed and connected to the fire system.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>Hazardous areas were evaluated</p>	01/17/2012			

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	<p>Based on interview on 12/16/11 concurrent with the observations with the Maintenance Supervisor, the aforementioned doors leading into storage rooms were not equipped with self closing devices on either door.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 metal rolling doors separating the kitchen, a hazardous area, from the corridor would close automatically with the fire alarm system to maintain a smoke resistant barrier. This deficient practice could affect 6 residents observed in the Main dining room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 12/16/11 at 11:35 a.m. with the Maintenance Supervisor, there was one metal rolling fire door protecting the opening from the kitchen to the exit access corridor on Main front hall which did not have an inspection tag, or close automatically with the actuation of the fire alarm system. Based on interview on 12/16/11 at 11:29 a.m. with the Maintenance Supervisor, it was acknowledged the metal fire door did not close automatically upon actuation of the fire alarm.</p>		<p>to ensure proper door closures were in place and identified deficiencies were corrected.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>Maintenance Director will ensure that changes to room functionality are compliant with Life Safety Code. Hazardous areas were evaluated to ensure proper door closures were in place and identified deficiencies were corrected.</p> <p>The relay will be checked semi-annually in conjunction with the sprinkler system check by an outside vendor.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</b></p> <p>Audit findings will be presented to QA&amp;A committee monthly for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring per the QA&amp;A process.</p>		

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K0046 SS=E	<p>3.1-19(b)</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 11 battery operated lights were maintained to provide emergency powered illumination. LSC 7-9.2 requires emergency lighting shall be provided for not less than 1 1/2 hours, be arranged to provide not less than an average of 1 foot candle and not less than 0.1 foot candles measured along the path of egress at floor level. This deficient practice could affect 8 residents on Medicare back hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 12/16/11 at 1:39 p.m. with the Maintenance Supervisor, the battery powered emergency light located in the Mechanical room on Medicare back hall did not illuminate when tested.</p> <p>Based on interview on 12/16/11 at 1:41 p.m. with the Maintenance Supervisor, it was confirmed the battery powered</p>	K0046	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Emergency light on the back of Medicare hall was replaced.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>Emergency lights were tested to ensure proper functionality with any identified deficiencies corrected.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>Maintenance Director or designee will perform weekly checks to ensure proper functionality.</p>	01/17/2012

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K0048 SS=E	<p>emergency light did not illuminate when tested.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice affects any resident, staff and visitors in the vicinity of the kitchen.</p>	K0048	<p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</b></p> <p>Audit findings will be presented to QA&amp;A committee monthly for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring per the QA&amp;A process.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Emergency Response Plan was updated to include the use of ABC and K-class fire extinguishers located in the kitchen.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>Dietary staff will be educated on the changes to the Emergency Response Manual.</p> <p><b>What measures will be put into place or what systemic changes will be made to</b></p>	01/17/2012	

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K0056 SS=E	<p>Findings include:</p> <p>Based on review of the facility's written Emergency Response Manual on 12/16/11 at 3:45 p.m. with the Maintenance Supervisor, the plan did not include the use of the ABC or K class fire extinguishers located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview on 12/16/11 at 3:50 p.m. with the Maintenance Supervisor, it was acknowledged the Emergency Response Manual did not include mention of the ABC or K class fire extinguisher.</p> <p>3.1-19(b)</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview,</p>	K0056	<p><b>ensure that the deficient practice does not recur?</b></p> <p>Annual education will be provided to staff regarding the Emergency Response Manual.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</b></p> <p>Audit findings will be presented to QA&amp;A committee monthly for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring per the QA&amp;A process.</p> <p><b>What corrective action(s) will be accomplished for those</b></p>	01/17/2012	

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	<p>the facility failed to ensure 2 of 2 sprinkler heads in the Ancillary storage room on 500 hall were installed a minimum of 6 feet apart. NFPA 13, Section 5-6.3.4, "Minimum Distance between Sprinklers", states sprinklers shall be spaced not less than 6 feet on center. In addition, LSC 19.1.1.4.5 requires minor renovations, alterations, modernizations, or repairs shall not reduce life safety below the level that previously existed. This deficient practice could affect 6 residents on 500 hall as well as visitors and staff</p> <p>Findings include:</p> <p>Based on observation on 12/16/11 at 12:40 p.m. with the Maintenance Supervisor, the Ancillary storage room on 500 hall had two sprinkler heads which were four feet apart. Based on interview on 12/16/11 at 12:42 p.m. with the Maintenance Supervisor, it was acknowledged the two sprinkler heads in the Ancillary storage room on 500 hall were less than six feet apart.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 1 combustible exterior canopies which was wider than 4 feet.</p>		<p><b>residents found to have been affected by the deficient practice?</b></p> <p>Deficient sprinkler heads in the Ancillary Storage Room on the 500 hall will be spaced six feet apart.</p> <p>Sprinkler coverage will be provided in the exterior canopy on the 300 hall and the kitchen freezer.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>Facility wide audit will be completed to ensure sprinkler system provides adequate coverage per the Life Safety Code.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>Maintenance Director will ensure that changes to functionality in the building are compliant with Life Safety Code including sprinkler heads being a minimum of 6 feet apart.</p> <p><b>How the corrective action(s) will be monitored to ensure the</b></p>		

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	<p>NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect 11 residents as well as visitors and staff using the 300 hall exit.</p> <p>Findings include:</p> <p>Based on observation on 12/16/11 at 1:02 p.m. with the Maintenance Supervisor, the canopy outside the 300 hall exit extended more than four feet from the building and was not provided with automatic sprinklers. The canopy was constructed of vinyl with aluminum supports. Based on interview on 12/16/11 at 1:04 p.m. with the Maintenance Supervisor, it was acknowledged the vinyl canopy was greater than four feet in width and he was not aware this requirement pertained to vinyl canopies.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 2 coolers were provided with an automatic sprinkler system to ensure sprinkler coverage in all portions of the building. This deficient practice could affect 6 residents in the Main dining room adjacent to the kitchen as well as visitors and staff.</p>		<p><b>deficient practice will not recur?</b></p> <p>Audit findings will be presented to QA&amp;A committee monthly for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring per the QA&amp;A process.</p>		

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K0062 SS=E	<p>Findings include:</p> <p>Based on observation on 12/16/11 at 1:17 p.m. with the Maintenance Supervisor, the kitchen freezer on Main front hall adjacent to the Main dining room was not provided with a sprinkler head. Based on interview on 12/16/11 at 1:18 p.m. with the Maintenance Supervisor, it was acknowledged a sprinkler head was not present in the kitchen freezer to provide complete sprinkler coverage.</p> <p>3.1-19(b)</p> <p>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. This deficient practice could affect 61 residents</p>	K0062	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p>	01/17/2012	

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K0064 SS=E	<p>on Family tree as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 12/16/11 at 12:15 p.m. with the Maintenance Supervisor, seven ceiling tiles were missing in the Eagle storage room on Family Tree which could delay sprinkler system activation in the event of a fire. Based on interview on 12/16/11 at 12:17 p.m. with the Maintenance Supervisor, it was acknowledged seven of fifteen ceiling tiles were missing.</p> <p>3.1-19(b)</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable</p>	K0064	<p>The missing ceiling tiles in the Eagle Room storage area were replaced.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>Building wide rounds completed to ensure ceiling tiles are in place.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>Maintenance Director or designee will perform weekly rounds ceiling tiles are properly placed.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</b></p> <p>Audit findings will be presented to QA&amp;A committee monthly for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring per the QA&amp;A process.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been</b></p>	01/17/2012	

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	<p>ABC class fire extinguisher pressure gauge readings was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect 8 residents as well as visitors and staff on Medicare back hall.</p> <p>Findings include:</p> <p>Based on observation on 12/16/11 at 2:45 p.m., the gauge on the ABC class portable fire extinguisher located in the Mechanical room on Medicare back hall showed the extinguisher was overcharged. Based on interview on 12/16/11 at 2:46 p.m. with the Maintenance Supervisor, it was acknowledged the gauge reading was not in the normal operating range and did not know if it would affect the operation of the fire extinguisher.</p> <p>3.1-19(b)</p>		<p><b>affected by the deficient practice?</b> The fire extinguisher on the Medicare back was replaced immediately. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> Fire extinguishers will be checked to ensure proper functionality inclusive of pressure gauge readings within acceptable parameters. Identified deficiencies will be corrected. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> Maintenance Director or designee will perform monthly check to ensure proper functionality of fire extinguishers. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</b> Audit findings will be presented to QA&amp;A committee monthly for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring per the QA&amp;A process.</p>		

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K0066 SS=E	<p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, record review and interview; the facility failed to ensure cigarette butts were deposited into a noncombustible container provided for 1 of 2 areas where smoking was permitted and ensure a metal container with a self closing lid was provided outside the Employee breakroom exit smoking area. This deficient practice could affect 3 residents on Main hall center as well as visitors and staff.</p> <p>Findings include:</p>	K0066	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Facility ordered metal self closing trash cans for proper disposal of cigarette butts in designated smoking areas.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p>	01/17/2012

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K0070 SS=E	<p>Based on observation on 12/16/11 at 2:15 p.m. with the Maintenance Supervisor, a plastic thirty gallon trash container used for paper goods in the smoking area just outside the Employee breakroom on Main hall center was used for the disposal of two hundred cigarette butts. Based on review of the smoking policy on 12/16/11 at 3:32 p.m. with the Maintenance Supervisor, the smoking policy did address the proper disposal of extinguished cigarette butts. Based on interview on 12/16/11 at 3:38 p.m. with the Maintenance Supervisor, it was acknowledged the facility's employees disposed of cigarette butts into an unapproved plastic container with paper goods, or on the ground.</p> <p>3.1-19(b)</p> <p>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to provide documentation for the use of 1 of 1 portable heating units used in nonsleeping staff areas. This</p>	K0070	<p>Facility will ensure that proper containers are available for disposal of cigarette butts.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>Staff will be educated regarding disposing of cigarette butts in appropriate containers. Random audits will be completed to ensure compliance with Life Safety Code.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</b></p> <p>Audit findings will be presented to QA&amp;A committee monthly for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring per the QA&amp;A process.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Portable space heating</b></p>	01/17/2012	

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K0144 SS=F	<p>deficient practice could affect 3 residents observed standing in the hall next the the Business Manager's office on Main front hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 12/16/11 at 11:15 p.m. with the Maintenance Supervisor, the business office next to the Administrative office on Main hall front contained one portable space heater which was not operating at the time, but documentation was not available to verify the heating elements did not exceed two hundred and twelve degrees F. Based on interview on 12/16/11 at 11:17 p.m. with the Maintenance Supervisor, it was acknowledged the information for the portable heating units, though not in use, was not available for review to verify the portable heating units did not exceed two hundred and twelve degrees F, and the facility did not have a portable heating unit policy.</p> <p>3.1-19(b)</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p>		<p>devices were removed. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> Building wide sweep conducted to identify presence of portable space heating devices. If noted, they were removed. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> Managers were educated regarding prohibition of portable space heating devices per Life Safety Code. Random audits will be completed to ensure compliance with Life Safety Code. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</b> Audit findings will be presented to QA&amp;A committee monthly for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring per the QA&amp;A process.</p>		

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	<p>Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation of generator equipment on 12/16/11 at 12:45 p.m. with the Maintenance Supervisor, a remote shut off device was not found for the generator. Based on review of Generator Maintenance records on 12/16/11 at 3:30 p.m. with the Maintenance Supervisor, the generator was installed in 2004 and a</p>	K0144	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Remote manual stop was installed on the emergency generator. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> Additional facility generator inspected to confirm remote manual stop in place. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> Proper functionality of the remote manual stop will be tested as part of the load bank testing. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</b> Audit findings will be presented to QA&amp;A committee monthly for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring per the QA&amp;A process.</p>	01/17/2012	

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

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FORM APPROVED

OMB NO. 0938-0391

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	remote means to shut the generator off was not provided. Based on interview on 12/16/11 at 12:48 p.m. with the Maintenance Supervisor, it was acknowledged the facility was unaware a remote shut off for the generator was required.  3.1-19(b)				