

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2014
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NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619
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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: 02/19/14</p> <p>Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist and Brett Overmyer, Life Safety Code Specialist.</p> <p>At this Life Safety Code survey, West Bend Nursing and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. Building 01 was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This facility consists of three connected buildings: Building 01, a two story, fully sprinklered building of Type II (222)</p>	K010000	K010000 The Creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	

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>construction; Building 02, a one story, fully sprinklered building of Type V (000) construction with a partial basement and Building 03, a one story, fully sprinklered building of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke detectors in all resident rooms. The facility has a capacity of 177 and had a census of 97 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/27/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 SS=E	<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. Based on observation and interview, the facility failed to ensure 2 of 70 corridor doors closed and latched into the door frame. This deficient practice would affect at least 10 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 02/19/14 from 12:15 p.m. to 3:45 p.m., the doors to the Physician's clinic and Therapy gym did not latch in their frames. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K010018	<p>K018 - The doors to the Physician's Clinic, Break Room and the Therapy Gym have been repaired to ensure that the doors latch into their frame. All residents have the ability to be affected. The Maintenance staff conducted a full facility audit of all of the corridor doors to ensure they properly latch. The Maintenance Supervisor or designee will monitor the locks/latching devices throughout the facility. Doors will be reviewed as part of the CQI program. The Maintenance Director or designee will audit locks/latching devices monthly for at least 6 months. The Maintenance Director or designee will record their findings on the "locks/latching devices" audit tool. If the audit results in anything lower than 100% then the Director or designee will</p>	03/21/2014	

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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>Based on observation and interview, the facility failed to ensure exit access was arranged so 1 of 2 exits from the main dining room was readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1 requires that means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. In addition to providing the required width to allow all occupants safe access to a public way, such access also needs to meet the requirements with respect to maintaining the means of egress free of obstructions that would prevent its use, such as snow and the need for its removal in some climates or soft ground during heavy periods of rain. This deficient practice could affect any resident, staff or visitor using the main dining room.</p>	K010038	<p>correct the deficiency immediately. Systemic changes will be completed by March 21, 2014.</p> <p>K038 – A quote has been acquired by the facility for a local contractor to complete concrete work in order to create the proper means of egress from the main dining room to the public way. In order to ensure compliance the work will be completed in the second quarter of 2014 due to weather restrictions. All means of egress will be monitored during routine preventative maintenance for 6 months. This will be reviewed as part of the CQI process. All residents have the potential to be affected. The Maintenance Supervisor or designee will record their findings on the “Means of Egress” auditing tool. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. The work will be completed by June 30, 2014. Systemic changes will be completed by June 30, 2014. The contractor has provided a “letter of intent to complete work.” This letter is attached to this Plan of Correction.</p>	03/21/2014

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K010044 SS=E	<p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 02/19/14 from 12:15 p.m. to 3:45 p.m., the secondary exit from the main dining room to the exterior was provided with a concrete stoop outside the door but the means of egress from the main dining room did not terminate at a public way. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to maintain the fire rated separation in 1 of 1 fire rated walls between Building 01 and Building 02 with firestopped fire barrier penetrations. LSC Section 8.2.3.2.4.2 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 fire barrier shall be filled with a material capable of maintaining the fire resistance of the fire barrier or be protected by an approved device designed for the specific purpose.</p>	K010044	<p>K044 – It is the practice of West Bend Nursing and Rehab to ensure that all fire and smoke barriers are free of penetrations. The Maintenance Director filled in the penetrations between building 01 and building 02. The area above the ceiling between buildings 01 and 02 that had a 4 inch pipe sleeve that was not fire stopped has been fire stopped by the Maintenance Director. This work was completed on February 20th, 2014. The Maintenance staff conducted a full facility audit to ensure that all fire barriers were fire stopped. The</p>	03/21/2014
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K010050 SS=F	<p>This deficient practice could affect at least all 10 residents as well as an undetermined number of staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor from 12:15 p.m. to 3:45 p.m. on 02/19/14, the fire barrier wall above the ceiling tiles at the Building 01 and 02 separation on the "Old Skilled hall" had a four inch pipe sleeve with a bundle of cables running through it that was not fire stopped. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</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 1. Based on interview and record</p>	K010050	<p>Maintenance director will inspect all new construction or outside contractors areas to ensure they are fire stopped. All residents have the potential to be affected. The Maintenance Director or Designee will monitor smoke and fire barriers for 6 months. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. The Maintenance Director or designee will record their findings on the "Smoke/Fire Barrier" auditing tool. These logs will be audited as part of the CQI program. Systemic changes will be completed by March 21, 2014.</p>	03/21/2014			

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	<p>review, the facility failed to conduct quarterly fire drills on each shift for 2 of 4 quarters. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Reports" with the Maintenance Supervisor from 9:15 a.m. to 11:30 a.m. on 02/19/14, a fire drill was not documented for the second shift of the third quarter of 2013 and and a fire drill not accurately documented for the first shift of third quarter of 2013. Based on record review, there were two fire drills documented for the first shift of the second quarter of 2013 (04/22/13 at 10:10 a.m. and 05/31/13 at 6:45 a.m.). For the third quarter of 2013, the 07/31 drill lacked documentation of the year conducted as well as listing the incorrect time of the drill as 11:15 p.m. instead of 11:15 a.m. This was acknowledged by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to conduct fire drills at unexpected times in 3 of 4</p>		<p>or designee conducted all fire drills for first quarter 2014 and were conducted on all 3 shifts and at unexpected times.All residents have the potential to be affected. The Maintenance director or designee conducted all fire drills for first quarter 2014 and were conducted on all 3 shifts and at unexpected times.All fire drills will be conducted each quarter on each shift at unexpected times and will be reviewed monthly by the Executive Director. Fire drills will be recorded on the "Monthly Fire Drill Report." If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. The audits will be reviewed as part of the CQI program. Systemic changes will be completed by March 21, 2014.</p>		

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K010061 SS=F	<p>third shift fire drills. This deficient practice affects all occupants in the facility including staff and residents.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Reports" with the Maintenance Supervisor from 9:15 a.m. to 11:30 a.m. on 02/19/14, three of four third shift fire drills were conducted on 03/25/13 at 4:00 a.m., 09/30/13 at 5:00 a.m. and 12/19/13 at 5:00 a.m. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the fire drills were not held randomly.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 Based on observation and interview, the facility failed to electronically supervise 1 of 1 Post Indicator Valves (PIV). LSC Section 9.7.2.1 requires supervisory attachments to be installed and monitored for integrity in accordance</p>	K010061	K061 – A local contractor will electronically tie in the Post Indicator Valve to an electronic monitoring system in order to monitor for the integrity of the system. The work will be completed prior to the end of the	03/21/2014			

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K010064 SS=B	<p>with NFPA 72, National Fire Alarm Code and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. This deficient practice could affect all residents in the facility as well as staff and visitors, if the water to the sprinkler system was shut off and not detected due to lack of supervision.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor from 12:15 p.m. to 3:45 p.m. on 02/19/14, the Post Indicator Valve (PIV) outside the facility near the laundry lacked electronic supervision. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the PIV lacked electronic supervision.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of 20 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires</p>	K010064	<p>second quarter of 2014. All residents have the potential to be affected. The Maintenance Director or designee will monitor this system monthly for 6 months. The system will be reviewed as part of the CQI program. The Maintenance Director or designee will record the results of the audit on the "PIV Monitoring" tool. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. Systemic changes will be completed by March 21, 2014. The contractor has provided a "letter of intent to complete work." This letter is attached to this Plan of Correction.</p> <p>K064 – The Maintenance Director inspected the portable fire extinguisher behind the second floor nurses station on February 20th, 2014 and the tag has been replaced. All residents have the</p>	03/21/2014

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	<p>fire extinguisher inspections at least monthly with the date of inspection and the initials of the 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 number of residents or staff in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 02/19/14 from 12:15 p.m. to 3:45 p.m., the monthly inspection tag on the fire extinguisher located in the second floor Unit Manager's area lacked documentation of a monthly inspection for the month of January of 2014. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>potential to be affected. The Maintenance Director inspected all 20 portable fire extinguishers on February 20th, 2014 and documented that they had been inspected to ensure that they are available and will operate. The Maintenance Director or designee will complete the "Preventative Maintenance Performed This Month" auditing tool and reference "Fire Extinguishers" monthly as part of the preventative maintenance program and will update tags accordingly. The "Preventative Maintenance Performed This Month" tool will be reviewed as part of the CQI program. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. Systemic changes will be completed by March 21, 2014.</p>		

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, interview and record review; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any resident using the main dining room adjacent to the kitchen including staff or visitors.</p> <p>Findings include:</p> <p>Based on observation on 02/19/14 during the tour from 12:15 p.m. to 3:45</p>	K010130	K130 – “Over Head Door” will be performing an annual inspection on March 11th, 2014 to ensure that the door operates properly and fully closes. The contractor will provide this facility with the proper documentation as well as tag the door to validate the inspection. All residents have the potential to be affected. This is the only rolling door in the facility. The Maintenance Director or designee will ensure that the annual inspection is completed as part of the preventative maintenance program. The Maintenance Director or designee will ensure that the rolling door operates properly, three times per month during fire drills. The results of the inspection will be recorded on the “Fire drill” worksheet and will be reviewed as part of the CQI process. Systemic changes will be completed by March 21, 2014.	03/21/2014	

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K010144 SS=F	<p>p.m. with the Maintenance Supervisor, there was a rolling fire door protecting the opening from the kitchen to the main dining room without an attached inspection tag. Based on interview on 02/19/14 and fire alarm record review from 9:15 a.m. to 11:30 a.m. with the Maintenance Supervisor, it was acknowledged there was no documentation of an annual inspection or test to check for proper operation and full closure of the vertical rolling fire door.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 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>	K010144	K144 –A local contractor will move the generators annunciator panels to locations that are monitored 24 hours a day. The work will be completed by March 10th, 2014. All residents have the potential to be affected. These are the only 2 annunciator panels that we have in the facility. The Maintenance Director or designee will monitor the panels as part of the preventative maintenance program. The Maintenance Director or designee will monitor	03/21/2014			

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K010147 SS=B	<p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 02/19/14 from 12:15 p.m. to 3:45 p.m., a generator remote annunciator for the "small" generator serving Building 01 was not provided. Based on interview at the time of observation, the Maintenance Supervisor acknowledged a remote annunciator for the "small" generator was not provided.</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>Based on observation and interview, the facility failed to ensure extension cords including powerstrips and nonfused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 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 cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect residents as well as staff in the</p>	K010147	<p>the panels as part of the preventative maintenance program. The results of the monitoring will be reported as part of the CQI process. Systemic changes will be completed by March 21, 2014.</p> <p>K147 – The Maintenance Director removed the power strip that the refrigerator in the recreation office was plugged into on February 19th, 2014. The Maintenance Director removed the power strip that the refrigerator, microwave and coffee pot were plugged into in the Environmental Services Office on February 19th, 2014. All residents have the potential to be affected. The Maintenance Director completed an audit of the entire facility on February 20th, 2014 to ensure that there was not any use of power strips that did not comply with LSC K147. The facility was 100% in compliance. The Maintenance Director or</p>	03/21/2014	

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NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619		
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K020000	<p>Recreation Center.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor from 12:15 p.m. to 3:45 p.m. during a tour of the facility on 02/19/14, a refrigerator was plugged into a power strip in the Recreation Center office. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <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: 02/19/14</p> <p>Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist and Brett Overmyer, Life Safety Code Specialist.</p>	K020000	<p>designee will complete an all staff in service to educate the staff not to utilize power strips. The Maintenance Director or designee will perform a Power Strip Audit weekly for 4 weeks and then monthly for 6 months to ensure compliance. This audit will be recorded on the "Power Strip" audit tool. The results of this audit will be reviewed as part of the CQI program. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. Systemic changes will be completed by March 21, 2014.</p> <p>K010000 The Creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p>		

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	<p>At this Life Safety Code survey, West Bend Nursing and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. Building 02 was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This facility consists of three connected buildings: Building 01, a two story, fully sprinklered building of Type II (222) construction; Building 02, a one story, fully sprinklered building of Type V (000) construction with a partial basement and Building 03, a one story, fully sprinklered building of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke detectors in all resident rooms. The facility has a capacity of 177 and had a census of 97 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p>			

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K020018 SS=E	<p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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. Based on observation and interview, the facility failed to ensure 1 of 70 corridor doors closed and latched into the door frame. This deficient practice would affect at least 10 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 02/19/14 from 12:15 p.m. to 3:45 p.m., the door to the Employee Break room did not latch in the frame. This was</p>	K020018	<p>K018 - The doors to the Physician's Clinic, Break Room and the Therapy Gym have been repaired to ensure that the doors latch into their frame. All residents have the ability to be affected. The Maintenance staff conducted a full facility audit of all of the corridor doors to ensure they properly latch. The Maintenance Supervisor or designee will monitor the locks/latching devices throughout the facility. Doors will be reviewed as part of the CQI program. The Maintenance Director or designee will audit locks/latching devices monthly for</p>	03/21/2014

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K020029 SS=E	<p>acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <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 5 of 10 doors serving hazardous areas such as a laundry or areas larger than 50 square feet storing combustible materials closed and latched to prevent the passage of smoke. This deficient practice could affect 10 residents as well as staff and visitors on the old skilled hall.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K020029	<p>at least 6 months. The Maintenance Director or designee will record their findings on the "locks/latching devices" audit tool. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. Systemic changes will be completed by March 21, 2014.</p> <p>K029 – It is the practice of West Bend Nursing and Rehab to ensure that doors to hazardous areas are closed and latched.</p> <p>A. The three laundry room doors have been equipped with self closure devices and latch into their frames. B. The door to Room 16 (Nursing Supply) has been equipped with a self closure device. C. The door to the Admission Storage room has been equipped with a self closure device. The Maintenance Director audited all doors that required automatic closures on</p>	03/21/2014	

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K020044 SS=E	<p>Maintenance Supervisor during a tour of the facility on 02/19/14 from 12:15 p.m. to 3:45 p.m., the following was noted:</p> <p>a. The three laundry room doors lacked door closers and functioning latching devices.</p> <p>b. The door to Room 16 (Nursing Supply) lacked a door closer. This room exceeded 50 square feet in size and was being used for the storage of 75 to 100 cardboard boxes and combustible nursing supplies.</p> <p>c. The door to Admission storage lacked a door closer. This room exceeded 50 square feet and was being used for the storage of 15 to 20 cardboard boxes.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned doors did not self close and latch to prevent the passage of smoke.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to maintain the fire rated separation in 1 of 1 fire rated walls between Building 01 and Building 02 with firestopped fire barrier</p>	K020044	<p>February 20th, 2014. All residents have the potential to be affected. The Maintenance Supervisor or designee will monitor the automatic closure devices throughout the facility. Doors will be reviewed as part of the CQI program. The Maintenance Director or designee will record their findings on the "locks/latching devices" auditing tool. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. Systemic changes will be completed by March 21, 2014.</p> <p>K044 – It is the practice of West Bend Nursing and Rehab to ensure that all fire and smoke barriers are free of penetrations. The Maintenance Director filled in the penetrations between building</p>	03/21/2014

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	<p>penetrations. LSC Section 8.2.3.2.4.2 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 fire barrier shall be filled with a material capable of maintaining the fire resistance of the fire barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect at least all 10 residents as well as an undetermined number of staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor from 12:15 p.m. to 3:45 p.m. on 02/19/14, the fire barrier wall above the ceiling tiles at the Building 01 and 02 separation on the "Old Skilled hall" had a four inch pipe sleeve with a bundle of cables running through it that was not fire stopped. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>01 and building 02. The area above the ceiling between buildings 01 and 02 that had a 4 inch pipe sleeve that was not fire stopped has been fire stopped by the Maintenance Director. This work was completed on February 20th, 2014. The Maintenance staff conducted a full facility audit to ensure that all fire barriers were fire stopped. The Maintenance director will inspect all new construction or outside contractors areas to ensure they are fire stopped. All residents have the potential to be affected. The Maintenance Director or Designee will monitor smoke and fire barriers for 6 months. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. The Maintenance Director or designee will record their findings on the "Smoke/Fire Barrier" auditing tool. These logs will be audited as part of the CQI program. Systemic changes will be completed by March 21, 2014.</p>		

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K020050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>1. Based on interview and record review, the facility failed to conduct quarterly fire drills on each shift for 2 of 4 quarters. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Reports" with the Maintenance Supervisor from 9:15 a.m. to 11:30 a.m. on 02/19/14, a fire drill was not documented for the second shift of the third quarter of 2013. Based on record review, there were two fire drills documented for the first shift of the second quarter of 2013 (04/22/13 at 10:10 a.m. and 05/31/13 at 6:45 a.m.) and one fire drill for the third shift on 06/19/13 at 3:00 a.m. A fire drill was not accurately documented for the first shift of the first shift drill documented as occurring on "07/31" which lacked</p>	K020050	K050 – The Maintenance director or designee conducted all fire drills for first quarter 2014 and were conducted on all 3 shifts and at unexpected times. All residents have the potential to be affected. The Maintenance director or designee conducted all fire drills for first quarter 2014 and were conducted on all 3 shifts and at unexpected times. All fire drills will be conducted each quarter on each shift at unexpected times and will be reviewed monthly by the Executive Director. Fire drills will be recorded on the "Monthly Fire Drill Report." If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. The audits will be reviewed as part of the CQI program. Systemic changes will be completed by March 21, 2014.	03/21/2014	

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	<p>documentation of the year conducted as well as listing the incorrect time of the drill as 11:15 p.m. instead of 11:15 a.m. This was acknowledged by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to conduct fire drills at unexpected times in 3 of 4 third shift fire drills. This deficient practice affects all occupants in the facility including staff and residents.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Reports" with the Maintenance Supervisor from 9:15 a.m. to 11:30 a.m. on 02/19/14, three of four third shift fire drills were conducted on 03/25/13 at 4:00 a.m., 09/30/13 at 5:00 a.m. and 12/19/13 at 5:00 a.m. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the fire drills were not held randomly.</p> <p>3.1-19(b) 3.1-51(c)</p>						

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K020056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system 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 for 1 of 1 shower rooms on the "Old Skilled Hall". NFPA 13, Section 5-1.1 states sprinklers shall be installed throughout the premises. NFPA 13, Section 4-6.1.4 states sprinklers shall not be obstructed by auxiliary devices, piping, insulation, and so forth, from detecting fire or from proper distribution of water. NFPA 13, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge or additional sprinklers shall be provided to ensure</p>	K020056	<p>K056 –A local contractor will relocate the sprinkler head in the "Old Skilled Spa" in order to create the sprinkler protection coverage necessary to provide adequate sprinkler protection. The work will be completed prior to March 21, 2014. No residents reside in this area. The Maintenance Director or designee completed an audit of all sprinkler heads to ensure that they provided adequate sprinkler protection. If construction; the area will be audited to ensure that the sprinkler continues to provide adequate protection. The Maintenance Director or designee will monitor sprinkler heads on routine rounds. The results of the audit will be recorded bi-annually as they are tested. Sprinkler heads will be reviewed as part of the CQI program.Systemic</p>	03/21/2014
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K020061 SS=F	<p>adequate coverage of the hazard. This deficient practice could affect residents and staff on the Old Skilled Hall.</p> <p>Findings include:</p> <p>Based on observation on 02/19/14 with the Maintenance Supervisor from 12:15 p.m. to 3:45 p.m., the "Old Skilled Spa" lacked complete sprinkler protection. The one side wall sprinkler was partially blocked by a four inch sprinkler pipe and the shower stall wall at the back of the shower room. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on observation and interview, the facility failed to electronically supervise 1 of 1 Post Indicator Valves (PIV). LSC Section 9.7.2.1 requires supervisory attachments to be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm</p>	K020061	<p>changes will be completed by March 21, 2014.</p> <p>K061 – A local contractor will electronically tie in the Post Indicator Valve to an electronic monitoring system in order to monitor for the integrity of the system. The work will be completed prior to the end of the second quarter of 2014. All residents have the potential to be</p>	03/21/2014			

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K020062 SS=B	<p>Code and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. This deficient practice could affect all residents in the facility as well as staff and visitors, if the water to the sprinkler system was shut off and not detected due to lack of supervision.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor from 12:15 p.m. to 3:45 p.m. on 02/19/14, the Post Indicator Valve (PIV) outside the facility near the laundry lacked electronic supervision. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the PIV lacked electronic supervision.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition. This</p>	K020062	<p>affected. The Maintenance Director or designee will monitor this system monthly for 6 months. The system will be reviewed as part of the CQI program. The Maintenance Director or designee will record the results of the audit on the "PIV Monitoring" tool. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. Systemic changes will be completed by March 21, 2014. The contractor has provided a "letter of intent to complete work." This letter is attached to this Plan of Correction.</p> <p>K062 – The Maintenance department replaced the 8 ceiling tiles in the storage room adjacent to the laundry room on February 20th, 2014. No residents reside in this area. The maintenance</p>	03/21/2014

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K020064 SS=B	<p>deficient practice could affect staff in the adjacent laundry area.</p> <p>Findings include:</p> <p>Based on observation on 02/19/14 during the tour from 12:15 p.m. to 3:45 p.m. with the Maintenance Supervisor, eight ceiling tiles were missing in the storage room located adjacent to the laundry which could delay sprinkler system activation in the event of a fire. Based on interview during the time of observation, the Maintenance Supervisor acknowledged the ceiling tiles were missing.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of 20 portable fire extinguishers 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 person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a</p>	K020064	<p>Director completed a facility audit to ensure that all ceiling tiles were in place. The Maintenance Director or designee will audit the ceiling tiles throughout the facility at least monthly as part of the preventative maintenance program and the results of those audits will be documented for 6 months. These results will be reviewed as part of the CQI program. The Maintenance Director or designee will record the results of these audits on the "Ceiling Tile" auditing tool. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. Systemic changes will be completed by March 21, 2014.</p> <p>K064 – The Maintenance Director inspected the portable fire extinguisher behind the second floor nurses station on February 20th, 2014 and the tag has been replaced. All residents have the potential to be affected. The Maintenance Director inspected all 20 portable fire extinguishers on February 20th, 2014 and documented that they had been inspected to ensure that they are available and will operate. The</p>	03/21/2014

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NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619			
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K020144 SS=F	<p>"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 number of residents or staff in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 02/19/14 from 12:15 p.m. to 3:45 p.m., the monthly inspection tag on the fire extinguisher located outside the Employee Break room exit lacked documentation of a monthly inspection for the month of January of 2014. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <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. Based on observation and interview, the</p>	K020144	<p>Maintenance Director or designee will complete the "Preventative Maintenance Performed This Month" auditing tool and reference "Fire Extinguishers" monthly as part of the preventative maintenance program and will update tags accordingly. The "Preventative Maintenance Performed This Month" tool will be reviewed as part of the CQI program. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. Systemic changes will be completed by March 21, 2014.</p> <p>K144 –A local contractor will move the generators annunciator</p>	03/21/2014			

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K020147 SS=B	<p>facility failed to ensure 1 of 2 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 Supervisor on 02/19/14 from 12:15 p.m. to 3:45 p.m., a generator remote annunciator for the "big "generator serving Building 02 was provided in the Memory Care Facilitator's office. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the Memory Care Facilitator's office was formerly part of the nurses' station before the Auguste's Cottage was remodeled last year and is not staffed on a 24 hour basis.</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>panels to locations that are monitored 24 hours a day. The work will be completed by March 10th, 2014. All residents have the potential to be affected. These are the only 2 annunciator panels that we have in the facility. The Maintenance Director or designee will monitor the panels as part of the preventative maintenance program. The Maintenance Director or designee will monitor the panels as part of the preventative maintenance program. The results of the monitoring will be reported as part of the CQI process. Systemic changes will be completed by March 21, 2014.</p>				

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K030000	<p>Based on observation and interview, the facility failed to ensure extension cords including powerstrips and nonfused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 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 cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff in the Environmental office.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor from 12:15 p.m. to 3:45 p.m. during a tour of the facility on 02/19/14, a refrigerator, microwave and a coffee pot were plugged into a power strip in the Environmental office. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and</p>	K020147	<p>K147 – The Maintenance Director removed the power strip that the refrigerator in the recreation office was plugged into on February 19th, 2014. The Maintenance Director removed the power strip that the refrigerator, microwave and coffee pot were plugged into in the Environmental Services Office on February 19th, 2014. All residents have the potential to be affected. The Maintenance Director completed an audit of the entire facility on February 20th, 2014 to ensure that there was not any use of power strips that did not comply with LSC K147. The facility was 100% in compliance. The Maintenance Director or designee will complete an all staff in service to educate the staff not to utilize power strips. The Maintenance Director or designee will perform a Power Strip Audit weekly for 4 weeks and then monthly for 6 months to ensure compliance. This audit will be recorded on the “Power Strip” audit tool. The results of this audit will be reviewed as part of the CQI program. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. Systemic changes will be completed by March 21, 2014.</p>	03/21/2014			
		K030000	K010000 The Creation and submission of this plan of				

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	<p>State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/19/14</p> <p>Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist and Brett Overmyer, Life Safety Code Specialist.</p> <p>At this Life Safety Code survey, West Bend Nursing and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. Building 03 was surveyed with Chapter 18, New Health Care Occupancies</p> <p>This facility consists of three connected buildings: Building 01, a two story, fully sprinklered building of Type II (222) construction; Building 02, a one story, fully sprinklered building of Type V (000) construction with a partial</p>		correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.				

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K030050 SS=F	<p>basement and Building 03, a one story, fully sprinklered building of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke detectors in all resident rooms. The facility has a capacity of 177 and had a census of 97 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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. 18.7.1.2</p> <p>1. Based on interview and record review, the facility failed to conduct quarterly fire drills on each shift for 2 of</p>	K030050	K050 – The Maintenance director or designee conducted all fire drills for first quarter 2014 and	03/21/2014			

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	<p>4 quarters. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Reports" with the Maintenance Supervisor from 9:15 a.m. to 11:30 a.m. on 02/19/14, fire drills were not accurately documented for the second shift of the third quarter of 2013 and the first shift of third quarter of 2013. Based on record review, there were two fire drills documented for the first shift of the second quarter of 2013 and for the third quarter of 2013, the 07/31 drill lacked documentation of the year conducted as well as listing the incorrect time of the drill as 11:15 p.m. instead of 11:15 a.m.. This was acknowledged by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to conduct fire drills at unexpected times in 3 of 4 third shift fire drills. This deficient practice affects all occupants in the facility including staff and residents.</p>		<p>were conducted on all 3 shifts and at unexpected times. All residents have the potential to be affected. The Maintenance director or designee conducted all fire drills for first quarter 2014 and were conducted on all 3 shifts and at unexpected times. All fire drills will be conducted each quarter on each shift at unexpected times and will be reviewed monthly by the Executive Director. Fire drills will be recorded on the "Monthly Fire Drill Report." If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. The audits will be reviewed as part of the CQI program. Systemic changes will be completed by March 21, 2014.</p>		

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K030061 SS=F	<p>Findings include:</p> <p>Based on review of "Fire Drill Reports" with the Maintenance Supervisor from 9:15 a.m. to 11:30 a.m. on 02/19/14, three of four third shift fire drills were conducted on 03/25/13 at 4:00 a.m., 09/30/13 at 5:00 a.m. and 12/19/13 at 5:00 a.m. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the fire drills were not held randomly.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on observation and interview, the facility failed to electronically supervise 1 of 1 Post Indicator Valves (PIV). LSC Section 9.7.2.1 requires supervisory attachments to be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. This deficient practice could</p>	K030061	K061 – A local contractor will electronically tie in the Post Indicator Valve to an electronic monitoring system in order to monitor for the integrity of the system. The work will be completed prior to the end of the second quarter of 2014. All residents have the potential to be affected. The Maintenance Director or designee will monitor this system monthly for 6 months. The system will be reviewed as part of the CQI program. The Maintenance	03/21/2014	

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	<p>affect all residents in the facility as well as staff and visitors, if the water to the sprinkler system was shut off and not detected due to lack of supervision.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor from 12:15 p.m. to 3:45 p.m. on 02/19/14, the Post Indicator Valve (PIV) outside the facility near the laundry lacked electronic supervision. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the PIV lacked electronic supervision.</p> <p>3.1-19(b)</p>		<p>Director or designee will record the results of the audit on the "PIV Monitoring" tool. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. Systemic changes will be completed by March 21, 2014. The contractor has provided a "letter of intent to complete work." This letter is attached to this Plan of Correction.</p>				