

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155402	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/27/2014
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NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906
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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: 02/27/14</p> <p>Facility Number: 000271 Provider Number: 155402 AIM Number: 100291260</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Heritage Healthcare 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 consists of the original building of Type II (000) construction and the 1989 addition of a north wing and extension to an east wing of Type V (111) construction. Since the buildings were all constructed</p>	K010000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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	<p>prior to March 1, 2003, they were surveyed as one building of Type V (111). The facility is sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors and in spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 120 and had a census of 85 at the time of this survey.</p> <p>All areas where residents have customary access are sprinklered except those cited at K-56. Equipment storage pods located in the back parking lot and an HVAC closet in the Occupational Therapy Directors office are not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/06/14.</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 doors protecting corridor openings in 1 of 9 smoke compartments could automatically latch into their door frames. This deficient practice affects staff, visitors and 10 or more residents on Earhart hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 at 2:55 p.m., the door protecting the corridor opening to resident room 10 on Earhart hall was tested three times with the Maintenance Director, each time the door failed to latch securely into the door frame. It could be pushed open without turning</p>	K010018	<p>K018</p> <p>1. Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice.</p> <p>2. Corrective action for those residents who have the potential to be affected: Residents who reside in the facility have the potential to be affected by the alleged deficient practice.</p> <p>3. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur: The door latch was adjusted on 2/27/14 in order to shut securely.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The Maintenance Director/Designee</p>	03/29/2014			

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K010021 SS=E	<p>the door knob.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure doors serving hazardous areas such as a kitchen, laundry larger than 100 square feet, storage rooms for soiled linen and waste receptacles of more than 32 gallons, and storage room for combustibles larger than 50 square feet in 5 of 9 smoke compartment were held open only by a</p>			K010021	<p>will audit the functioning of the door through our Preventive Maintenance program weekly x 4 weeks then monthly x 5 months. Any audits not reaching 95% compliance will be taken to PI monthly for further review and recommendations.</p> <p>K021</p> <p>1. Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice.</p> <p>2. Corrective action for those residents who have the potential to be affected:</p>		03/29/2014

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	<p>device arranged to automatically close the door upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 20 or more residents in the main dining room, the Laundry hall, Ross hall, Earhart hall and west Duncan hall smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 at 3:00 p.m., the access door to the kitchen dishwashing room, equipped with a closer designed to automatically close upon activation of the fire alarm system was prevented from closing by a food cart and 50 gallon waste receptacle placed in the path of the door's swing. The Maintenance Director acknowledged at the time of observation, the self closer was ineffective if the door was blocked.</p> <p>b. Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 at 3:10 p.m., the Ross hall shower room was used for the collection of six, 50 gallon soiled linen and trash receptacles which were more than half full. The door stood wide open. The door was equipped with a self closing device which, when the door was pushed wide open, the self closer</p>				<p>Residents who reside in the facility have the potential to be affected by the alleged deficient practice.</p> <p>3. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur: Staff to be inserviced prior to 3/29/14 on not obstructing doors that automatically close upon activation of the fire alarm system. In addition a new self closing mechanism was added on 3/17/14 to the Ross Hall shower room.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The Maintenance Director/Designee will audit the functioning of self closing fire activated doors through our Preventive Maintenance program weekly x 4 weeks then monthly x 5 months. Any audits not reaching 95% compliance will be taken to PI monthly for further review and recommendations.</p>		

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	<p>prevented the door from closing automatically. The same condition was observed for the Earhart hall shower room door, a room also used for the storage of soiled linen and trash receptacles on 02/27/14 at 3:10 p.m. The Maintenance Director confirmed at the time of observations, the self closers were preventing the doors from closing.</p> <p>c. Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 at 11:20 a.m., the Duncan Hall charting and medical supply storage room door was held wide open by a chart rack placed in front of the open door. The door was equipped with a self closing device. The room was 80 square feet in size and housed shelves laden with more than 10 combustible cardboard cartons and other plastic wrapped medical supplies. At 4:40 p.m. on 02/27/14, the same door was observed with the maintenance director and Maintenance # 1 to be prevented from closing by a cardboard carton. The Maintenance Director acknowledged at the times of observation, the door could not close automatically.</p> <p>e. Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 at 5:25 p.m., the self closing laundry room door was held wide open by a laundry cart. At 5:35</p>			

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K010025 SS=E	<p>p.m. on 02/27/14, the laundry cart was gone and the door was open three inches because a sweater hanging on the door knob prevented it from closing. The room was unoccupied. The Maintenance Director acknowledged at the time of observation, the door should not have been held open.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>1. Based on observation and interview, the facility failed to provide complete smoke barriers for 3 of 8 smoke barrier walls. LSC Section 8.3.2 requires smoke barriers to be continuous through all concealed spaces, such as those found above a ceiling. This deficient practice affects visitors, staff and 10 or more residents protected by the Ross</p>	K010025	<p>K025</p> <p>1. Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice.</p> <p>2. Corrective action for those residents who have the potential to be affected:</p>	03/29/2014

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	<p>hall, Stuart hall and east Duncan hall smoke barriers.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 between 4:00 p.m. and 5:40 p.m., smoke barriers providing separation for the Stuart hall, the east Duncan hall and Earhart hall from adjacent smoke compartments were incomplete. Each of the smoke barriers terminated at some point above the ceiling rather than continuing to the roof deck above. The Maintenance Director acknowledged the incomplete status of the smoke barriers at the time of observations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure ceiling and wall smoke barrier penetrations in 2 of 9 sprinklered smoke compartments were sealed, or sealed in a manner which maintained the one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of</p>		<p>Residents who reside in the facility have the potential to be affected by the alleged deficient practice.</p> <p>3. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur: **Quotes being obtained in order to complete smoke barriers above the ceiling so they comply with code standards to continue to the roof deck. Due to the scope of work that will be required to meet the standards of this alleged deficient practice, the facility would like to request an additional 30 days to complete the work.**</p> <p>Gaps that were identified as deficient will be sealed with approved materials designed for the purpose of maintaining the resistance of the smoke barrier prior to 3/29/14.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The Maintenance Director/Designee will audit the integrity of the maintenance performed to the identified deficiencies through our Preventive Maintenance program weekly x 4 weeks then monthly x 5 months. Any audits not reaching 95% compliance will be taken to PI monthly for further review and recommendations.</p>				

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	<p>maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. LSC Section 8.3.2 requires smoke barriers to be continuous from floor to ceiling and outside wall to outside wall. This deficient practice could affect visitors, staff and 10 or more residents in the Ross hall, Stuart Hall, Duncan Hall and adjacent spaces.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director between 3:00 p.m. and 5:40 p.m., ceiling and wall penetrations were found:</p> <p>a. Unsealed around the sprinkler pipe penetrating the ceiling above the Ross hall eyewash station leaving a gap of one half inch into the attic above;</p> <p>b. Incompletely sealed around the ill fitting attic access panel in the Ross hall shower room which allowed a one quarter inch gap along one side of the access panel into the attic above;</p> <p>c. Unsealed in the Physical Therapy furnace closet where the dry wall mud and tape had fallen away leaving a four by one inch opening into the attic above the</p>						

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	<p>ceiling;</p> <p>d. Improperly sealed in the attic above the west Duncan hall smoke barrier where three, four inch pipes providing conduit for bundles of wires and cables had been sealed with expandable foam;</p> <p>e. Unsealed around ceiling penetrations in the Stuart hall utility room leaving 1/2 inch gap into the attic.</p> <p>The Maintenance Director acknowledged at the time of observations, all gaps should have been maintained and sealed with approved materials designed for the purpose of maintaining the resistance of the smoke barrier.</p> <p>3.1-19(b)</p>						

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K010027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 7 smoke barrier door sets would self close to restrict the passage of smoke. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect staff, visitors and 10 or more residents on Ross hall and the adjacent smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 at 3:05 p.m., the Ross hall smoke barrier door set was tested twice manually and one door failed to close leaving a gap of two inches. The door failed to close again when the fire alarm was activated at 5:30 p.m. on</p>	K010027	<p>K027</p> <p>1. Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice.</p> <p>2. Corrective action for those residents who have the potential to be affected: Residents who reside in the facility have the potential to be affected by the alleged deficient practice.</p> <p>3. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur: The Ross Hall smoke barrier door has been fixed by removing the door jamb and replacing to ensure it closes properly on 3/7/14.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The Maintenance Director/Designee will audit the functioning of the door through our Preventive</p>	03/29/2014			

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K010029 SS=E	<p>02/27/14. The Maintenance Director acknowledged at the time of observations, the doors were warped but they should have closed.</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>1. Based on observation and interview, the facility failed to provide automatic door closers on a door providing access to a hazardous area in 1 of 9 smoke compartments. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of</p>	K010029	<p>Maintenance program weekly x 4 weeks then monthly x 5 months. Any audits not reaching 95% compliance will be taken to PI monthly for further review and recommendations.</p> <p>K029</p> <p>1. Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice.</p> <p>2. Corrective action for those residents who have the potential to</p>	03/29/2014			

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	<p>the fire alarm system. This deficient practice could affect visitors, staff and 10 or more residents in the center Duncan Hall smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 at 4:20 p.m., the 27 by 25 foot activities office, storage and activity room was lined with cabinets shelves and tables laden with paper and plastic wrapped activities supplies and miscellaneous craft items. The room was used for the storage of floor style electric popcorn machine which used oil for popping the corn. The Maintenance Director said at the time of observation, the machine was operated in that room. The door was not self closing. There was evidence a self closer had been originally in place. Screws filled holes in the door and frame which matched those which might have been used to anchor a self closer.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure doors to hazardous areas in 1 of 9 smoke compartments such as the kitchen would latch. Doors to hazardous areas are</p>		<p>be affected:</p> <p>Residents who reside in the facility have the potential to be affected by the alleged deficient practice.</p> <p>3. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur: A self closure device has been ordered and will be added to the activity room door prior to 3/29/14 and a latching mechanism will be added to the kitchen double doors prior to 3/29/14 as well.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The Maintenance Director/Designee will audit the functioning of the doors through our Preventive Maintenance program weekly x 4 weeks then monthly x 5 months. Any audits not reaching 95% compliance will be taken to PI monthly for further review and recommendations.</p>		

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	<p>required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects visitors, kitchen staff and 10 or more residents in the adjacent dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 at 2:55 p.m., a double door provided access to the kitchen from the main dining room. The dining room was open to the corridor. One door had slide bolt latches which secured it to the top and bottom of the door frame, the second door had a self closer which allowed the door to close upon activation of the fire alarm system. There was no latch to keep the door tightly closed. The Maintenance Director said at the time of observation, the door secured with the slide bolt latches "was never opened." He acknowledged it could be opened and would not automatically latch into the door frame.</p> <p>3.1-19(b)</p>				

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K010046 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review and interview, the facility failed to provide complete documentation of 30 second testing at 30 day intervals for battery powered emergency lighting fixtures provided in 9 of 9 smoke compartments. LSC 7.9.3 requires a functional test shall be conducted on every required battery powered emergency lighting system at</p>	K010046	<p>K046</p> <p>1. Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice.</p> <p>2. Corrective action for those residents who have the potential to be affected:</p>	03/29/2014			

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	<p>30 day intervals for not less than 30 seconds. Written records of visual inspections and tests shall be kept. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of facility Emergency Light test records with the Maintenance Director on 02/27/14 at 5:35 p.m., the battery powered emergency lighting test records documented the 1 1/2 hour annual tests and any battery changes made for each device, however, entry for monthly testing was limited to a single check for the testing of all the devises each month on a preventive maintenance record. The Maintenance Director said at the time of record review, "I do all of them" but did not record the results of monthly testing for each device separately.</p> <p>3.1-19(b)</p>		<p>Residents who reside in the facility have the potential to be affected by the alleged deficient practice.</p> <p>3. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur: Maintenance Director has updated his emergency lighting test audit tool to include proof of testing each individual light in order to meet standards.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The Maintenance Director/Designee will audit the functioning of the emergency lighting tool weekly x 4 weeks then monthly x 5 months. Any audits not reaching 95% compliance will be taken to PI monthly for further review and recommendations.</p>		

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K010050 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 record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for all staff during 2 of the last 4 quarters. LSC 4.7.2 requires drills include suitable procedures to ensure that all persons subject to the drill participate. This deficient practice could effect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill records and interview with the Maintenance Director on 02/27/14 at 12:10 p.m., the three shifts providing staffing by nurses differed from those of the certified nursing assistants (CNA). Nurse shifts were identified by the Maintenance Director as first shift 7:00 a.m. to 3:30 p.m., second shift 3:30 p.m. to 11:00 p.m., and third shift 11:00 p.m.</p>	K010050	<p>K 050 1. Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice. 2. Corrective action for those residents who have the potential to be affected: Residents who reside in the facility have the potential to be affected by the alleged deficient practice. 3. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur: Staff to be inserviced on procedures for responding to fire situations and familiar with special extinguishing systems prior to 3/29/14 and Maintenance Director adjusted the fire drill scheduled times on 2/28/14 in order to capture all staff in the drills. 4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The Maintenance Director/Designee will conduct fire drill audits and staff</p>	03/29/2014	

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	<p>to 7:00 a.m. CNA shifts were reported as first shift 6:00 a.m. to 2:30 p.m., second shift 2:30 p.m. to 10:00 p.m., and third shift 10:00 p.m. to 6:00 a.m. Computer generated Logbook Documentation was provided as evidence of the fire drills conducted with an Inservice Education Report and Attendance Form with signatures and titles of attendees. A close review of actual fire drill times revealed fire drills conducted during the third shift dated 6/28/13 and 12/30/13 at 10:30 p.m. would not provide training for nurses scheduled to start work at 11:00 p.m. Second shift fire drills recorded for 6/28/13 at 2:45 p.m. and 11/26/13 at 2:39 p.m. would likewise fail to include nurses starting at 3:00 p.m. The Maintenance Director acknowledged the discrepancy and said he had no other record to evidence the quarterly training for scheduled nurses who would not have participated in these drills on the second and third shifts.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on interview and record review, the facility failed ensure all staff were familiar with the procedures for responding to fire situations and familiar with special extinguishing systems in 1</p>		<p>knowledge auditing weekly x 4 weeks then monthly x 5 months. Any audits not reaching 95% compliance will be taken to PI monthly for further review and recommendations.</p>				

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	<p>of 1 kitchens. LSC 19.7.2.2 requires a written health care occupancy fire safety plan which shall provide policy and procedures for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect visitors, staff and 10 or more residents in the adjacent main dining room.</p> <p>Findings include:</p> <p>Based on an interview with Cook # 1 on 02/27/14 at 2:55 p.m. with the Maintenance Director present, she was uncertain when asked what action she would take if the commercial cooking range became engulfed in fire and the automatic extinguishing system failed to activate automatically. She hesitated and said, "I don't know, get a fire extinguisher I guess." She further stated she had been the cook for "three months." The Maintenance Director acknowledged at the time of interview, Cook # 1 was at risk for injury to herself</p>			
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	<p>and others if she did not respond appropriately to a special fire situation likely to occur in the kitchen. A review of the General Fire Plan with the Maintenance Director on 02/27/14 at 11:55 a.m. included included procedures specific to different departments in the facility, however, there was no evidence kitchen staff had been trained in the emergency operation procedure for the commercial cooking fire extinguishing system and any special response. Their actions were limited to shutting down appliances and responding to a general alarm. The Maintenance Director acknowledged at the time of interview, the kitchen staff were lacking in some training specific to fire systems in their work area. On 02/27/14 at 6:00 p.m., the Maintenance Director further explained a fire safety contractor addressed specific area emergency responses during an annual inservice but Cook # 1 may not have attended.</p> <p>3.1-19(b)</p>				

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to provide complete sprinkler coverage for 1 of 9 smoke compartments in a one story building of Type V (111) construction. LSC 19.1.6.2 requires one story facilities of Type V (111) construction be provided with complete sprinkler protection. This deficient practice affects residents, staff, and 10 or more residents in the east Duncan Hall smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 02/27/14 at 5:45 p.m., sprinkler protection was not provided for the HVAC closet in the Occupational Therapy director's office. The Maintenance Director</p>	K010056	<p>K056</p> <p>1. Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice.</p> <p>2. Corrective action for those residents who have the potential to be affected: Residents who reside in the facility have the potential to be affected by the alleged deficient practice.</p> <p>3. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur: The sprinkler heads identified as deficient have been corrected by addition to sprinkler in HVAC room and Sprinklers on Duncan and Medical records office removed in order to meet compliance.</p> <p>4. Corrective actions will be monitored to ensure the alleged</p>	03/29/2014			

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	<p>acknowledged at the time of observation, the closet was not sprinklered.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to insure 2 of 9 smoke compartments had sprinkler heads installed in accordance with NFPA 13, Section 5-1.1 and 5-6.3.4 which requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect staff, visitors and 10 or more residents on Duncan hall.</p> <p>Findings include:</p> <p>a. Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 at 4:25 p.m., the Duncan hall shower room had three sprinkler heads located less than six feet from one another. The sprinkler heads were measured at distances of two and three quarters feet, three and one half feet, and two and one half feet from from each other. The Maintenance Director confirmed the separation of sprinkler heads was less than six feet.</p> <p>b. Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 at 6:20 p.m., the separation between two sprinkler heads</p>		<p>deficient practice does not re occur by:</p> <p>The Maintenance Director/Designee will audit the functioning of sprinklers through our Preventive Maintenance program weekly x 4 weeks then monthly x 5 months. Any audits not reaching 95% compliance will be taken to PI monthly for further review and recommendations.</p>	

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K010062 SS=E	<p>in the medical records office measured four foot six inches. The Maintenance Director confirmed the separation of sprinkler heads was less than six feet.</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>1. Based on observation and interview, the facility failed to ensure sprinkler heads in 3 of 9 smoke compartments were free of foreign materials. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 20 or more residents in the laundry and main dining room smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K010062	<p>K062</p> <p>1. Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice.</p> <p>2. Corrective action for those residents who have the potential to be affected: Residents who reside in the facility have the potential to be affected by the alleged deficient practice.</p> <p>3. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur:</p>	03/29/2014			

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	<p>Maintenance Director and Maintenance # 1 on 02/27/14 between 11:20 a.m. and 3:55 p.m., two sprinkler heads in the laundry were covered with a gray fuzzy coating; four sprinkler heads protecting the kitchen had a coating of brown grime, and an unidentified white residue was noted on two sprinkler heads in resident room 22. The Maintenance Director agreed at the time of observations, there should have been no foreign materials on the sprinkler heads.</p> <p>3.1-19(b)</p> <p>2. Based on observation, the facility failed to ensure sprinkler heads providing protection for 5 of 9 smoke compartments were maintained. This deficient practice could affect all staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 between 11:20 a.m. and 3:55 p.m., sprinkler head escutcheons were missing, improperly installed or displaced leaving gaps of 1/4 to 1/2 inches into the attic above:</p> <p>a. Two escutcheons were displaced from sprinkler heads protecting the central lobby leaving an annular</p>		<p>The sprinklers identified have been cleaned and sealed and some replaced and new sprinkler heads for the kitchen have been ordered and will be installed in the kitchen prior to 3/29/14.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by:</p> <p>The Maintenance Director/Designee will audit the cleanliness and functionality of the sprinklers through our Preventive Maintenance program weekly x 4 weeks then monthly x 5 months. Any audits not reaching 95% compliance will be taken to PI monthly for further review and recommendations.</p>				

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	<p>gap of 1/4 inch;</p> <p>b. One escutcheon in the conference room hung a 1/2 inch below the ceiling sprinkler head;</p> <p>c. A 1/2 inch annular gap was observed around the sprinkler head in the closets for resident rooms 24 and 36;</p> <p>d. An escutcheons was missing from the sprinkler head in resident room 39 leaving a 1/2 inch annular gap into the attic above;</p> <p>e. A 1/4 inch annular gap was found at the ceiling sprinkler head in the housekeeping office on Duncan hall.</p> <p>f. A 1/4 inch annular gap around a sprinkler escutcheon and a missing escutcheon in the medical records office;</p> <p>g. An escutcheon was displaced in resident room 67 leaving an annular gap of 1/4 inch.</p> <p>The Maintenance Director acknowledged at the time of observations, these sprinklers were in need of maintenance.</p> <p>3.1-19(b)</p>				

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K010064 SS=D	<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 ensure annual and monthly checks were provided for 1 of 1 portable fire extinguishers located at the exterior exit from the laundry smoke compartment. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. NFPA 10, 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance an extinguisher will operate effectively and safely. NFPA 10, 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition</p>	K010064	<p>K064</p> <ol style="list-style-type: none"> Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice. Corrective action for those residents who have the potential to be affected: Residents who reside in the facility have the potential to be affected by the alleged deficient practice. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur: Annual inspection has been completed on all fire extinguishers and the fire extinguisher located outside the laundry smoke compartment has been added to the Maintenance Directors preventive 	03/29/2014
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	<p>NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. This deficient practice could affect affect 2 visitors and 4 staff in an area where smoking was occurring. No residents were observed in the area.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 at 2:30 p.m., the last monthly inspection date noted on the service and inspection tag for the portable fire located outside the laundry smoke compartment exit was 12/2/13. The Maintenance Director acknowledged at the time of observation, the fire extinguisher should have been checked every month.</p> <p>3.1-19(b)</p>		<p>maintenance monthly audit on 3/17/14.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by:</p> <p>The Maintenance Director/Designee will inspect the fire extinguishers through our Preventive Maintenance program weekly x 4 weeks then monthly x 5 months. Any audits not reaching 95% compliance will be taken to PI monthly for further review and recommendations.</p>				

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K010066 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, interview, and record review, the facility failed to enforce the facility wide smoking policy for the protection of 85 of 85 residents. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 at 11:25 a.m., a smoking tower was located outside the laundry smoke compartment exit. A fire</p>	K010066	<p>K066</p> <p>1. Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice.</p> <p>2. Corrective action for those residents who have the potential to be affected: Residents who reside in the facility have the potential to be affected by the alleged deficient practice.</p> <p>3. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur:</p>	03/29/2014	

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	<p>extinguisher and fire blanket were available attached to the outside wall. Four staff were observed to be smoking and the exit way was the entry point for some vendors and staff. On 02/27/14 at 11:30 a.m., the Maintenance Director identified a designated smoking area located outside between the Earhart and Ross halls. The sheltered area was designed and equipped with a self closing metal container for cigarette waste disposal, noncombustible ashtrays and a can for trash. The Maintenance Director said at the time of observation, the use of the area was not permitted in "bad weather" such as excessively cold weather which was the current situation. The area appeared unused as evidenced by the untracked blanket of snow on the access path to the smoking area. A review of the smoking policy was reviewed with the Maintenance Director on 02/27/14 at 12:20 p.m. The policy noted, "Smoking is only permitted in the designated area of the courtyard." Smoking was not to be permitted for "individuals admitted after 10/1/09." No mention of the smoking area in use outside the laundry smoke compartment exit was mentioned, nor limitations or requirements for visitor and staff smoking. The Maintenance Director agreed at the time of record review, the smoking policy as written, was not being</p>		<p>The smoking policy has been updated to include staff and visitor designated smoking areas and staff to be inserviced prior to 3/29/14. 4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The Maintenance Director/Designee will audit the enforcement of the smoking policy through our Preventive Maintenance program weekly x 4 weeks then monthly x 5 months. Any audits not reaching 95% compliance will be taken to PI monthly for further review and recommendations.</p>				

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K010070 SS=E	<p>enforced.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to provide evidence 1 of 1 space heaters was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice affects visitors staff and 10 or more residents in the east Duncan hall smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Director and Maintenance # 1 on 2/27/14 at 6:20 p.m., a portable space heater, air conditioning and humidifier unit stood in the unoccupied medical records office. The unit was not in use. The Maintenance Director described the function of the unit, that it was plugged in to a wall outlet for power, and used in the medical records office periodically.</p>	K010070	<p>K070</p> <p>1. Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice.</p> <p>2. Corrective action for those residents who have the potential to be affected: Residents who reside in the facility have the potential to be affected by the alleged deficient practice.</p> <p>3. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur: The portable heater has been removed from the Medical Records office on 2/28/14.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The Maintenance Director/Designee</p>	03/29/2014			

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K010072 SS=E	<p>He said he didn't consider the unit a portable space heater. He said he had no documentation with regard to the temperature limit of the heating element and no policy and procedure to review for use of such equipment.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure 1 of 9 exit means of egress were free of all obstructions which could interfere with its full instant use. This deficient practice affects visitors, staff and 10 or more residents on Duncan hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Maintenance</p>	K010072	<p>will audit that no portable heaters or related devices are in function throughout the building Preventive Maintenance program weekly x 4 weeks then monthly x 5 months. Any audits not reaching 95% compliance will be taken to PI monthly for further review and recommendations.</p> <p>1. Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice.</p> <p>2. Corrective action for those residents who have the potential to be affected: Residents who reside in the facility have the potential to be affected by the alleged deficient practice.</p> <p>3. Measures/Systemic changes</p>	03/29/2014			

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	# 1 on 02/27/14 at 11:20 a.m., a 50 gallon mobile linen barrel, wheelchair, and Hoyer lift were located opposite one another in the Duncan Hall exit access corridor outside room 42 leaving three feet of egress access. At 5:15 p.m. on 02/27/14, an electric wheelchair and Hoyer lift were observed on opposite sides of the Duncan hall exit access corridor near room 50 with the Maintenance Director and Maintenance # 1. The remaining egress space was measured at 36 inches. The Maintenance Director acknowledged at the time of observation, the equipment was an impediment to instant use of the exit access in the event of an emergency. 3.1-19(b)		put into place to assure alleged deficient practice does not re occur: Staff to be inserviced prior to 3/29/14 to educate on means of egress not being obstructed. 4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The Maintenance Director/Designee will audit the facility for blocked means of egress through our Preventive Maintenance program weekly x 4 weeks then monthly x 5 months. Any audits not reaching 95% compliance will be taken to PI monthly for further review and recommendations.				

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K010074 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure window valences in 3 of 9 smoke compartments were rendered flame resistant. LSC 19.7.5.1 requires draperies and other loosely hanging fabrics to be in accordance with 10.3.1. LSC 10.3.1 requires draperies, curtains, and other similar loosely hanging furnishings and decorations to have flame resistance as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice affects visitors, staff and 10 or more residents in the Earhart hall, the business office and the center Duncan hall smoke</p>	K010074	<p>K074</p> <p>1. Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice.</p> <p>2. Corrective action for those residents who have the potential to be affected: Residents who reside in the facility have the potential to be affected by the alleged deficient practice.</p> <p>3. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur: Flame resistance documentation for the valences identified in room 11, the business office, the activities room and the doctors office are</p>	03/29/2014			

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K010075 SS=E	<p>compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 between 3:15 and 4:45 p.m., flame resistance labeling was not found on window valances in resident room 11, the business office, the activities room, and doctor's office. The Maintenance Director said at the time of observations, he had no evidence the materials were treated to render them flame resistant.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 Based on observation and interview, the</p>	K010075	<p>being obtained and if can't be obtained, the valances will be removed prior to 3/29/14.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The Maintenance Director/Designee will audit for labeling for draperies and other similar loose hanging furnishings through our Preventive Maintenance program weekly x 4 weeks then monthly x 5 months. Any audits not reaching 95% compliance will be taken to PI monthly for further review and recommendations.</p>	03/29/2014			

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	<p>facility failed to keep 2 of 2 unattended trash collection receptacles with a capacity of more than 32 gallons within a 64 square foot area, in a room protected as a hazardous area. This deficient practice affects visitors, staff and 10 or more residents in the center lounge smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 between 11:30 a.m. and 7:45 p.m., two trash collection receptacles stood side by side in the corridor adjacent to the laundry entrance opening into the center lobby. The receptacles were not mobile, one was almost full of shredded paper and the second was half full. The Maintenance Director said on 02/27/14 at 2:40 p.m., he was uncertain about the exact capacity of the receptacles but he was sure they each had a capacity for more than 32 gallons. He said he didn't consider the shredded documents trash but agreed the shredded paper would be disposed of.</p> <p>3.1-19(b)</p>		<ol style="list-style-type: none"> Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice. Corrective action for those residents who have the potential to be affected: Residents who reside in the facility have the potential to be affected by the alleged deficient practice. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur: The receptacles identified were removed from the corridor immediately on 2/27/14. Staff will be inserviced prior to 3/29/14. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The Maintenance Director/Designee will audit that trash collection receptacles with capacities greater than 32 gallon are located in a room protected as a hazard area when not attended through our Preventive Maintenance program weekly x 4 weeks then monthly x 5 months. Any audits not reaching 95% compliance will be taken to PI monthly for further review and recommendations. 				

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K010130 SS=F	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review, observation and interview; the facility failed to provide evidence of a preventive maintenance program in accordance with the manufacturer's recommendations for cleaning battery operated smoke detectors in 60 of 60 resident sleeping rooms. LSC 4.6.12.2 requires any like safety code features obvious to the public, if not required by the Code, shall be maintained or removed. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the preventive maintenance records for the battery powered smoke detectors located in each resident room with the Maintenance Director and Maintenance # 1 on 02/27/14 at 12:50 p.m., documentation of a regular cleaning was not found. The manufacturer's recommendation was immediately reviewed and noted the devices should be cleaned at least monthly. The Maintenance Director said at the time of record review, the smoke detectors were cleaned every time they were tested with a paint brush but he acknowledged he had not</p>	K010130	<p>K130</p> <p>1. Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice.</p> <p>2. Corrective action for those residents who have the potential to be affected: Residents who reside in the facility have the potential to be affected by the alleged deficient practice.</p> <p>3. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur: The cleaning of smoke detectors has been added to the Maintenance Directors monthly audit tool; the helium cylinder in the oxygen supply room was immediately secured by maintenance staff on 2/27/14.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The Maintenance Director/Designee will audit that helium cylinders in the facility are secured through our Preventive Maintenance program weekly x 4 weeks then monthly x 5 months. Any audits not reaching 95% compliance will be taken to PI monthly for further review and recommendations.</p> <p>5. Date of compliance: 3/29/14</p>	03/29/2014			

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	<p>documented the activity.</p> <p>3.1-19(a)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of non-flammable gas was secured in a cart or hand truck with appropriate chains or stays to prevent accidental damage. NFPA 99, 8-5.2.1.1 requires the construction for nonpatient gas cylinder carts and hand trucks shall be constructed for the intended purpose and shall be self-supporting. They shall be provided with appropriate chains or stays to retain cylinders in place. This deficient practice affects visitors, staff, and 10 or more residents in the center Duncan Hall smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 at 4:35 p.m., a helium cylinder was free standing in the Oxygen supply storage room between mobile liquid oxygen tanks. The Maintenance Director acknowledged the tank was not secured, at the time of observation, and said "the chain came out of the wall."</p> <p>3.1-19(b)</p>						

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K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring for 4 of 9 smoke compartments. NFPA 70 National Electrical Code, 1999 Edition, 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 10 or more residents on the Armstrong, Stuart, Duncan and Ross halls.</p> <p>Findings include:</p> <p>a. Based on interview with the Maintenance Director on 02/27/14 at 12:35 p.m., the facility had "plenty of heavy gauge extension cords" to use in the event of a power outage. He explained the extension cords were used to provide power to resident "medical</p>	K010147	<p>K147</p> <p>1. Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice.</p> <p>2. Corrective action for those residents who have the potential to be affected: Residents who reside in the facility have the potential to be affected by the alleged deficient practice.</p> <p>3. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur: Laundry/Housekeeping staff to be inserviced prior to 3/29/14; floor will be painted prior to 3/29/14 to show staff restricted areas to place equipment in regards to blocking electrical equipment.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by: The Maintenance Director/Designee</p>	03/29/2014			

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	<p>equipment" from outlets connected to the emergency generator on Earhart hall during a utility outage because it was the only hall with electrical receptacles connected to the emergency generator. During a tour of the facility with the Maintenance Director and Maintenance # 1 on 02/27/14 between 2:30 p.m. and 5:45 p.m., emergency electrical outlets were not observed on Armstrong, Stuart, Ross and Duncan Halls.</p> <p>b. Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 between 2:30 p.m. and 5:45 p.m., power strip extension cords were used to supply power to a feeding tube pump in room 8 on Earhart hall and a refrigerators in the conference room and maintenance shop. On Armstrong hall, a power strip extension cord was plugged into the bedside wall in resident room 67 to power a resident's personal electrical equipment. The maintenance director said at the time of observation, extension cords were discouraged but in some cases that there were not enough electrical outlets for the equipment needed.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure an electrical equipment room in 1 of 9 smoke</p>		will audit for compliance through our Preventive Maintenance program weekly x 4 weeks then monthly x 5 months. Any audits not reaching 95% compliance will be taken to PI monthly for further review and recommendations.				

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	<p>compartments was provided with sufficient access and working space to permit ready and safe operation and maintenance of the equipment. NFPA 70, Article 110.26 requires sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Table 110.26 (A)(1) requires a minimum of three feet of clear distance from the electrical equipment. This deficient practice affects 3 visitors, 4 or more staff and any residents in the laundry smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Maintenance # 1 on 02/27/14 at 2:30 p.m., an electrical circuit panel in the laundry was blocked by a laundry rack located 10 inches from the panel. The Maintenance Director moved the rack at the time of observation but it had been returned to the same position when observed again on 02/27/14 at 5:30 p.m. The Maintenance Director acknowledged at the time of observations, the rack was not positioned to allow a three foot access clearance to the panel.</p>						

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K010154 SS=F	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on observation and interview the facility failed to provide a complete written policy containing procedures to be followed to protect 85 of 85 residents in the event the automatic sprinkler system has to be placed out of service for four hours within a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be</p>	K010154	<p>K154</p> <p>1. Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice.</p> <p>2. Corrective action for those residents who have the potential to be affected: Residents who reside in the facility have the potential to be affected by the alleged deficient practice.</p> <p>3. Measures/Systemic changes put into place to assure alleged</p>	03/29/2014			

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	<p>instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's documentation of a plan of action when the fire alarm system was out of service for more than four hours in a twenty four hour period with the Maintenance Director on 02/27/14 at 1:00 p.m., a corporate generated policy entitled Failure-Fire Alarm System was provided. The document failed to include all elements required such as the implementation of a fire watch if the fire alarm system is out of service for four hours in a twenty four hour period, training of staff to respond appropriately upon discovery of fire, and the person conducting the fire watch shall have no other duties. The Maintenance Director</p>		<p>deficient practice does not re occur: The fire watch procedure in the event of a fire outage or sprinkler system outage has been updated to add implementation of fire watch if the fire alarm system is out of service, training of staff to respond appropriately upon discovery of fire and the person conducting the fire watch shall have no other duties. Staff to be inserviced prior to 3/29/14 on the updates.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur by:</p> <p>The Maintenance Director/Designee will audit staff knowledge of the updated policy through our Preventive Maintenance program weekly x 4 weeks then monthly x 5 months. Any audits not reaching 95% compliance will be taken to PI monthly for further review and recommendations.</p>				

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	<p>acknowledged at the time of record review, these elements of the fire watch requirement were omitted. At 2:20 p.m. on 02/27/14 a second document, untitled, undated and written on facility letterhead was produced. It was provided by Maintenance # 1 who had acquired it from the administrative offices. He said it was an addendum to their fire watch policy. The document simply noted "the DON or RN in charge will issue a 15 minute fire watch procedure in the event of a fire outage, or sprinkler system outage. In addition, Executive Director and Maintenance Supervisor to be notified immediately." The Maintenance Director conceded at the review of this document, he was unfamiliar with it and agreed it did not provide all elements required for an approved fire watch procedure.</p> <p>3.1-19(b)</p>				

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K010155 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on observation and interview the facility failed to provide a complete written policy including procedures to be followed to protect 85 of 85 residents in the event the fire alarm system has to be placed out of service for four hours within a 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's documentation provided for a plan of action when the fire alarm system was out of service for more than four hours in a twenty four hour period with the Maintenance Director on 02/27/14 at 1:00 p.m., the policy and procedure was not complete. The procedure titled Sprinkler System Outage did not include all elements required such as the implementation of a fire watch if the fire alarm system is out of service for four hours in a twenty four hour period,</p>	K010155	<p>K155</p> <p>1. Corrective action for the resident affected by the alleged deficient practice: No residents were affected by the alleged deficient practice.</p> <p>2. Corrective action for those residents who have the potential to be affected: Residents who reside in the facility have the potential to be affected by the alleged deficient practice.</p> <p>3. Measures/Systemic changes put into place to assure alleged deficient practice does not re occur: The fire watch procedure in the event of a fire outage or sprinkler system outage has been updated to add implementation of fire watch if the fire alarm system is out of service, training of staff to respond appropriately upon discovery of fire and the person conducting the fire watch shall have no other duties. Staff to be inserviced prior to 3/29/14 on the updates.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur</p>	03/29/2014			

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