

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/23/2015
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NAME OF PROVIDER OR SUPPLIER LAKELAND REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542
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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
K 000 Bldg. 01	<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: 03/23/2015</p> <p>Facility Number: 000491 Provider Number: 155495 AIM Number: 100291230</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist; Scott Wytosick, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Lakeland Rehabilitation and Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the</p>	K 000	<p>The facility requests paper compliance.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p>	

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

TITLE

(X6) DATE

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

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K 025 SS=E Bldg. 01	<p>corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 60 and had a census of 50 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility has a shed providing facility services including the storage of maintenance supplies and lawn equipment that was not sprinklered. The facility has two additional offsite storage units. One unit is used for the storage of maintenance parts and supplies and the other is used for the storage of activity supplies. The offsite storage units were not 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 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</p>			

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	<p>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 ensure the penetrations caused by the passage of wire and/or conduit through 1 of 4 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect two of four smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with Regional Director of Plant Operations on 03/23/2015 at 2:18 p.m. the 200 hall smoke barrier wall had unsealed penetrations above the ceiling tile. These unsealed penetrations included 3/4" to 2" holes to allow phone cables and sprinkler piping to pass through. Based on</p>	K 025	<p>K 025 NFPA 101 LIFE SAFETYCODE STANDARDS</p> <p>The facility requests paper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for rooms identified on 200 Hall:</p> <p>a. Based on observation on 03/23/15 at 2:29 p.m., the penetrations in the</p>	04/22/2015	

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	<p>interview, this was acknowledged by the Regional Director of Plant Operations at the time of observations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the penetrations for attic travel through 1 of 4 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect two of four smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with Regional Director of Plant Operations on 03/23/2015 at 2:29 p.m. the 200 hall smoke barrier wall had an unsealed access penetration. In the attic, a 2' by 3' rectangle was cut out of the smoke barrier</p>		<p>compartment smoke barrier was filled with fire retardant material. A conduit penetration in the barrier had been filled with fire caulk part of which had fallen out leaving a gap. Maintenance will ensure that identified smoke barriers are properly sealed with Fire Caulk. Based on observation on 03/23/15 at 2:18 p.m., a ¾" to 2" inch holes in the firewalls in the attic above. Maintenance has patched, sealed, and repaired the holes identified as being open in the attic between fire walls. Correction has been completed and facility will allege compliance April 22, 2015.</p> <p>b. Maintenance will ensure the 2' to 3' access penetration will be resealed with fire retardant dry wall and will make monthly inspections of smoke barrier areas to ensure all opening are properly sealed. Correction has been</p>	

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	for passage through the attic. Based on interview, this was acknowledged by the Regional Director of Plant Operations at the time of observations. 3.1-19(b)		completed and facility will allege compliance April 22, 2015. 2) How the facility identified other environmental concerns: a. A 100% smoke compartment/smoke barrier inspection has been completed by the maintenance director. 3) Measures put into place / System changes: a. Administrator/Designee will review maintenance records to ensure compliance monthly for six months and Corporate Environmental Consultants will review records and building during routine	

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			<p>monthly visits</p> <p>4) How the corrective actions will be monitored:</p> <p>a. Administrator/Designee will review maintenance records to ensure compliance monthly for six months and Corporate Environmental Consultants will review records and building during routine visits. If inspections identify areas needing additional repairs they are to be re-caulked and a record of repairs kept in the maintenance director's office.</p> <p>5) Responsible Person</p> <p>Administrator/Designee</p> <p>6) Date of Compliance</p> <p>Facility will allege</p>	

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K 038 SS=E Bldg. 01	<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 1 of 5 exit access corridors was readily accessible and unobstructed at all times. This deficient practice could affect any of the 15 residents in the 100 hall.</p> <p>Findings include:</p> <p>Based on an observation during the tour of the facility with the Regional Director of Plant Operations on 03/23/2015 at 12:19 p.m., the north exit near therapy had storage in the corridor. Storage included many rolls of carpet stacked at least 36", Based on an interview at the time of observation, the Regional Director of Plant Operations acknowledged these items were being stored in the corridor.</p> <p>3.1-19(b)</p>	K 038	<p>compliance April 22, 2015</p> <p>K 038 NFPA 101 LIFE SAFETYCODE STANDARDS</p> <p>The facility requests paper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for North exit identified on Therapy Hall:</p>	04/22/2015	

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			<p>a. Based on observation on 03/23/15 the exit corridor contained many rolls of carpet which was stacked at least 36". All items were removed from this area. Correction has been completed and the facility will allege compliance April 22, 2015.</p> <p>2) Measures put into place / System changes:</p> <p>a. Administrator/Designee and Director of Plant Operations will review construction areas on weekly rounds to ensure compliance monthly for six months and Corporate Environmental Consultants will review Maintenance records and building during routine visits.</p> <p>3) How the corrective</p>	

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K 039 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and		<p>actions will be monitored:</p> <ul style="list-style-type: none"> Administrator/Designee will review maintenance records to ensure compliance monthly for six months and Corporate Environmental Consultants will review records and building during routine visit. If inspections identify areas needing additional cleaning and clearing of exits immediate action will occur ensuring compliance. <p>4) Responsible Person</p> <p>Administrator/Designee</p> <p>5) Date of Compliance</p> <p>Facility will allege compliance April 22, 2015.</p>		

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	<p>unobstructed) serving as exit access is at least 4 feet. 19.2.3.3</p> <p>Based on observation and interview, the facility failed to ensure the corridor width for 1 of 1 Therapy exit corridors was at least four feet wide. This deficient practice affects any of the staff and any residents in the Therapy wing.</p> <p>Findings include:</p> <p>Based on an observation during the tour of the facility with the Regional Director of Plant Operations on 03/23/2015 between 12:19 p.m. the north exit in therapy had storage in the corridor. Storage included many rolls of carpet stacked at least 36", Based on an interview at the time of observation, the Regional Director of Plant Operations acknowledged these items were being stored in the corridor.</p> <p>3.1-19(b)</p>	K 039	<p>K 039 NFPA 101 LIFE SAFETYCODE STANDARDS</p> <p>The facility requests paper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for North exit identified on Therapy Hall:</p> <p>a. Based on observation on 03/23/15 the exit corridor contained many rolls of carpet which was stacked at least</p>	04/22/2015	

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			<p>36". All items were removed from this area. Correction has been completed and the facility will allege compliance April 22, 2015.</p> <p>2) Measures put into place / System changes:</p> <p>a. Administrator/Designee and Director of Plant Operations will review construction areas on weekly rounds to ensure compliance monthly for six months and Corporate Environmental Consultants will review Maintenance records and building during routine visits.</p> <p>3) How the corrective actions will be monitored:</p> <ul style="list-style-type: none"> • 		

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K 048 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to have 1 of 1 written health care occupancy fire safety plans	K 048	Administrator/Designee will review maintenance records to ensure compliance monthly for six months and Corporate Environmental Consultants will review records and building during routine visit. If inspections identify areas needing additional cleaning and clearing of exits immediate action will occur ensuring compliance. 4) Responsible Person Administrator/Designee 5) Date of Compliance Facility will allege compliance April 22, 2015. K 048 2015 NFPA 101 LIFE SAFETYCODE STANDARDS	04/22/2015	

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	<p>that incorporated all items listed in NFPA 101, Section 19.7.2.2.</p> <ol style="list-style-type: none"> 1. Use of alarms. 2. Transmission of alarms to 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 affects all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on record review on 03/23/2015 at 11:03 a.m. with the Regional Director of Plant Operations, the facility did not have evidence of a complete written health care occupancy fire safety plan or procedure. The fire safety plan titled "Fire" did not contain response to battery operated smoke alarms which were provided in the resident rooms. Based on interview, neither the Regional Director of Plant Operations nor the Administrator could provide documentation showing their procedure response to activated battery operated smoke alarms.</p> <p>3.1-19(b)</p>		<p>The facility requests paper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency of Fire exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for a written plan for the protection of all patients:</p> <p>a. Facility Fire Plan and Procedure has been updated to provide the required information of written health care occupancy fire safety plans that incorporate the following items.</p> <p>1.) Use of alarms.</p> <p>2.) Transmission of</p>		

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			<p>alarms.</p> <p>3.) Response to alarms.</p> <p>4.) Isolation of Fire.</p> <p>5.) Evacuation of immediate area.</p> <p>6.) Evacuation of smoke compartment.</p> <p>7.) Extinguishment of Fire.</p> <p>Copy of plan is now available in maintenance directors office in life safety manual and a copy is available in each the facilities nurses stations in the disaster manuals.</p> <p>2) Measures put into place / System changes:</p> <p>a.</p> <p>Facility training of staff and review of the Fire Plan</p>	

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			<p>will be ongoing during monthly fire drills. Administrator will ensure the Fire Plan and Procedure form becomes a part of new staff orientation by the maintenance director and a record for trainings will be included in the facility's records for employees.</p> <p>3) How the corrective actions will be monitored:</p> <p>a. Corporate Environmental Consultant will follow-up and review the plan during their routine visits to the facility. Administrator/Designee will review monthly at Quality Assurance meetings that facility fire plan and procedure has been reviewed by new employees receiving orientation by the facility. A record for Quality Assurance will be kept in the life safety manual in the maintenance office.</p>	

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K 050 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on interview and record review, the facility failed to conduct quarterly fire drills for Second and Third shift on the second quarter of 2014, and First shift in the third quarter. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p>	K 050	<p>4) Responsible Person</p> <p>Administrator/Designee</p> <p>5) Date of Compliance</p> <p>Facility will allege compliance April 22, 2015</p> <p>K 050 NFPA 101 LIFE SAFETYCODE STANDARDS</p> <p>The facility requests paper</p>	04/22/2015

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NAME OF PROVIDER OR SUPPLIER LAKELAND REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Report" with the Regional Director of Plant Operations at 11:48 a.m. on 03/23/2015, the following was noted:</p> <p>a) A fire drill was not documented for the second and third shifts of the second quarter of 2014.</p> <p>b) A fire drill was not documented for the first shift of the third quarter of 2014. Additionally, per interview during the review, there was no other documentation available for review to verify these drills were conducted.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for a written plan for the protection of all patients:</p> <p>a. Maintenance Director will ensure and provide Fire Drills at various times for each shift and record the results and report to become of monthly on going Quality Assurance meeting which is an electronic record.</p> <p>2) Measures put into place / System changes, How the corrective actions will be monitored:</p> <p>a. Administrator shall</p>		

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K 056 SS=E Bldg. 01	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		<p>follow-up with maintenance to ensure Fire Drills are being conducted properly at the Quality Assurance meetings. Correction will be started immediately with the next drill and Q.A. meeting scheduled for April 23, 2015.</p> <p>3) Responsible Person</p> <p>Administrator/Designee</p> <p>4) Date of Compliance</p> <p>Facility will allege compliance April 22, 2015.</p>		

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	<p>flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on written review and interview, the facility failed to ensure a low air alarm was installed in accordance NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 9-2.3.1.2 Pressure tanks shall be provided with an approved means for automatically maintaining the required air pressure. Where a pressure tank is the sole water supply, there shall also be provided an approved trouble alarm to indicate low air pressure and low water level with the alarm supplied from an electrical branch circuit independent of the air compressor. This deficient practice could affect all residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on written review of Inspection & Test Report by Koorsen Fire & Security, with the Regional Director of Plant Operations at 11:30 a.m. on 03/23/2015, Koorsen Fire & Security "suggest adding a low air switch, currently no way to monitor air pressure in dry system."</p> <p>Based on interview, the request for monitoring air pressure was acknowledged by the Regional Director of Plant Operations.</p>	K 056	<p>K 056 NFPA 101 LIFE SAFETYCODE STANDARDS</p> <p>The facility requests paper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for a written plan for the protection of all patients:</p> <p>a. Maintenance Director will ensure that Korsen Fire Protection systems will install a low air alarm in accordance with NFPA 13 standards. The low air alarm will include an independent electrical branch circuit</p>	04/22/2015

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	<p>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 the spray pattern for 1 of 1 sprinkler heads was unobstructed in the 200 hall nurse's station. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could affect 28 residents in the 200 hall</p> <p>Findings include:</p> <p>Based on observations during the tour of the facility with the Regional Director of Plant Operations on 03/23/2015 at 1:15 p.m. the 1 of 1 sprinkler head at the 200 hall nurse's station sprinkler head spray pattern was being obstructed by a light fixture. Based on interview, this was acknowledged by the Regional Director of Plant Operations at the time of</p>	K 062	<p>K 062 NFPA 101 LIFE SAFETYCODE STANDARDS</p> <p>The facility requests paper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for automatic sprinkler systems:</p> <p>a. Maintenance will remove obstruction by the 200 hall nurse's station sprinkler head by moving the light fixture near the sprinkler head to provide an unobstructed spray pattern.</p>	04/22/2015

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K 076 SS=D Bldg. 01	<p>observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p>		<p>2) Measures put into place / System changes:</p> <p>a. Administrator shall follow-up with maintenance to ensure sprinkler has an unobstructed path and a record of work will be kept in the Maintenance Director's office.</p> <p>4) Responsible Person</p> <p>Administrator/Designee</p> <p>5) Date of Compliance</p> <p>Facility will allege compliance April 22, 2015.</p>	
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	<p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 cylinder of nonflammable gases such as carbon dioxide was properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect anyone in the kitchen dry storage room which could affect staff.</p> <p>Findings include:</p> <p>Based on observation on 03/23/2015 at 1:36 p.m. with the Regional Director of Plant Operations, the facility failed to secure 1 of 1 carbon dioxide cylinders standing in the dry storage room. The regional director of plant operations agreed at the time of observation, the cylinder should have been properly secured with the chain provided.</p>	K 076	<p>K 076 NFPA 101 LIFE SAFETY CODE STANDARDS</p> <p>The facility requests paper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for Medical Gas Storage and Administration:</p> <p>a. Maintenance shall make a</p>	04/22/2015

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	3.1-19(b)		<p>100% inspection of kitchen and all common areas to ensure medical gas storage is properly chained and maintained in a proper storage area with proper signage.</p> <p>2) Measures put into place / System changes:</p> <p>a. Environmental services shall make weekly inspections of all common areas and resident rooms to ensure power strips are not being used in the facility as replacement for hard wired use.</p> <p>3) How the corrective actions will be monitored:</p> <p>a. Record of the inspection shall be a part of the weekly round tool kept with maintenance records and results to be recorded as part of that record.</p> <p>b. Administrator shall make weekly inspections of the common areas and rooms to ensure environmental services has been making the proper inspections</p> <p>4) Responsible Person</p> <p>Administrator/Designee</p>	

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K 147 SS=D Bldg. 01	<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, the facility failed to ensure extension cords including power strips and non-fused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, 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 at least one resident.</p> <p>Findings include:</p> <p>Based on observation on 03/23/2015 from 12:17 p.m. to 1:41 p.m. with the Regional Director of Plant Operations, an extension cord was found supplying power to a television and a LCD photo</p>	K 147	<p>5) Date of Compliance</p> <p>Facility will allege compliance April 22, 2015.</p> <p>K 147 NFPA 101 LIFE SAFETY CODE STANDARDS The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. 1) Immediate actions taken for Electrical wiring and equipment: a. Maintenance shall make a 100% inspection of all common areas, offices and rooms to ensure power strips are not being used in the facility as replacement for hard wired use. 2) How the corrective actions will be monitored: a. Record of the inspection shall be a part of the weekly round tool kept with maintenance records and results to be recorded as part of that record/work order. Environmental services will also report findings as rooms and common areas are</p>	04/22/2015

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	<p>frame in room 106. Based on interview, the Regional Director of Plant Operations acknowledged the deficiency.</p> <p>3.1-19(b)</p> <p>2. Based on observation, the facility failed to ensure extension cords including power strips and non-fused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, 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 at least one staff.</p> <p>Findings include:</p> <p>Based on observation on 03/23/2015 from 12:17 p.m. to 1:41 p.m. with the Regional Director of Plant Operations, a power strip was found supplying power to a refrigerator in the medical records room. Based on interview, the Regional Director of Plant Operations acknowledged the deficiency.</p> <p>3.1-19(b)</p>		<p>cleaned and will report findings to Maintenance at morning meetings. 3) Responsible Person Administrator/Designee/Maintenance/Environmental Services. 5) Date of Compliance Facility will allege compliance April 22, 2015.</p>		

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	<p>3. Based on observation, the facility failed to ensure extension cords including power strips and non-fused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, 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 at least 2 residents.</p> <p>Findings include:</p> <p>Based on observation on 03/23/2015 from 12:17 p.m. to 1:41 p.m. with the Regional Director of Plant Operations, a power strip cord was found supplying power to a patient's bed in room 201. Based on interview, the Regional Director of Plant Operations acknowledged the deficiency.</p> <p>3.1-19(b)</p>			