

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155343	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2016
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LAGRANGE	STREET ADDRESS, CITY, STATE, ZIP CODE 0770 N 075 E LAGRANGE, IN 46761
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K 0000 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>This survey was in conjunction with the investigation of Complaint Number IN00202253.</p> <p>Survey Date: 06/13/16</p> <p>Facility Number: 000235 Provider Number: 155343 AIM Number: 100267740</p> <p>At this Life Safety Code survey, Life Care Center of LaGrange was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors</p>	K 0000	The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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 0018 SS=E Bldg. 01	<p>and battery operated smoke detectors in all resident rooms. The facility has a capacity of 100 and had a census of 58 at the time of this survey.</p> <p>All areas where the residents have customary access and all areas providing facility services were sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist on 06/15/16</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>1. Based on observation and interview,</p>	K 0018	It is the practice of this facility to ensure the highest quality of care	07/13/2016

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	<p>the facility failed to ensure the 1 of 3 maintenance office doors protecting a corridor opening was smoke resistive. This deficient practice could affect up to 12 residents on the 100 hall.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Administrator on 06/13/16 at 11:21 a.m., there were two pencil size holes covered with tape in the corridor door of the maintenance shop. Based on interview, the Administrator acknowledges the holes at the time of observation.</p> <p>3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 main dining room doors, a pair of doors, were provided with positive latching hardware. This deficient practice could affect up to 40 residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Administrator on 06/13/16 at 12:05 p.m., the set of double doors form the corridor to the dining room, which did not contain smoke detectors/alarms, lacked a positive latching mechanism for one of the doors</p>		<p>is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> No residents affected by the deficient practice. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> No residents affected by the deficient practice. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> The maintenance door that had two pencil size holes was fixed. The facility installed two smoke detectors in the main dining room where the double doors are located. A door coordinator was installed on the double doors leading to the main dining room. An audit was done to see if any other doors had holes in them. The double doors leading to the main dining room were the only doors that needed a door coordinator. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> Main dining room double doors were the only doors in the facility that needed a door coordinator so no further monitoring needed. All facility doors were put on an internal inspection program to check for holes. The maintenance director or designee will perform quarterly checks with results forwarded to</p>				

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	<p>which manually latch into the frame. Based on interview at the time of observation, the Administrator acknowledged the door was not provided with positive latching hardware and the dining room did not contain any smoke detectors/alarms.</p> <p>3.1-19(b) 3. Based on observation, the facility failed to ensure 1 of 1 set of dining room doors were equipped with the appropriate hardware to allow the door that must close first, always closes first so that both doors will always close completely as a pair. Centers for Medicare & Medicaid Services (CMS) requires sets of double doors that swing in the same direction and equipped with an astragal to have a coordinator to ensure the door that must close first always closes first. This deficient practice affects up to 40 residents in the main dining.</p> <p>Findings include: Based on observation during the tour with the Administrator on 06/13/16 at 12:10 p.m., the main dining room double doors, which swung in the same direction and were equipped with an astragal, lacked a coordinator to allow the non-astragal side of the door to close first. Based on interview at the time of</p>		the facility performance improvement committee for further evaluation or resolution.				

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K 0021 SS=E Bldg. 01	<p>observation, the Administrator acknowledged the double doors lacked a coordinator.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2</p> <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. Based on observation and interview, the facility failed to ensure 1 of 1 Central Supply corridor doors were held open only by a device which would allow it to close automatically upon activation of the fire alarm system. This deficient practice could affect 26 residents in the 200 and</p>	K 0021	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was: No residents affected by the</i></p>	07/13/2016

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K 0025 SS=E Bldg. 01	<p>500 halls.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Administrator on 06/13/16 at 12:30 p.m., the Central Supply corridor door was propped open with a device that did not release with the fire alarm. The Central Supply room was over 50 square feet in size and contain combustible supplies. Based on interview, this was acknowledged by the Administrator at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of</p>	K 0025	<p>deficient practice. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> No residents affected by the deficient practice. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> The door stopper was removed that same day. The central supply person along with other office personnel was in-serviced on not to use door stoppers or other items to prop doors open. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> The maintenance director or designee will perform monthly checks on doors being propped open with results forwarded to the facility performance improvement committee for further evaluation or resolution.</p> <p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the</p>	07/13/2016	

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	<p>wire and/or conduit through 2 of 5 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 affects 29 residents in 2 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Administrator on 06/13/16 from 1:15 p.m. to 1:45 p.m., the following smoke barrier walls had unsealed penetrations:</p> <p>a) In the attic of the smoke barrier wall by the front lobby there was an unsealed one inch penetration around a pipe.</p> <p>b) In the attic of the smoke barrier wall to the 400 hall there was an unsealed one inch penetration around a pipe.</p> <p>Based on interview at the time of observations, the Administrator acknowledged and provided the</p>		<p>following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i></p> <p>No residents affected by the deficient practice. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i></p> <p>No residents affected by the deficient practice. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i></p> <p>The two attic smoke barriers that had the unsealed penetrations were fixed. The unsealed penetrations in the maintenance office and therapy kitchen were fixed. An audit was done to check the other smoke barriers along with other areas throughout the facility to make sure they were in compliance. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i></p> <p>The inspection of the smoke barrier walls in the attic will be added to the facilities preventative maintenance program. The maintenance director or designee will inspect the smoke barriers monthly and after contractors perform work up in the attic. The maintenance director or designee will perform quarterly audits for any unsealed penetrations. The results will be</p>				

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	<p>measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice affects 25 residents in 2 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Administrator on 06/13/16 from 9:11 a.m. to 12:00 p.m., the following areas had unsealed penetrations.</p> <p>a) In the ceiling of the maintenance office there were two unsealed fourth of an inch penetrations around PVC tubing.</p> <p>b) In the ceiling of the maintenance office there were two unsealed three inch penetrations through two PVC pipe sleeves that contained wires.</p> <p>c) In the ceiling of the therapy kitchen there was an unsealed half of an inch penetration around a conduit.</p> <p>Based on interview at the time of observations, the Administrator acknowledge and provided the</p>		forwarded to the facility performance improvement committee for further evaluation or resolution.		

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K 0029 SS=E Bldg. 01	<p>measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 hazardous areas, such as a room with a fuel fired water heater, was smoke resistive. This deficient practice could affect 20 residents on the 400 hall.</p> <p>Findings include:</p> <p>Based on observation during the tour with the Administrator on 6/13/16 at 12:34 p.m., the mechanical room on the 400 hall, which contained a fuel fired water heater, had 14 unsealed quarter inch penetrations around pipes, furthermore, there was an unsealed pipe sleeve containing wires. Based on interview at the time of observation, the</p>	K 0029	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> No residents affected by the deficient practice. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> No residents affected by the deficient practice. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> All 14 pipes with unsealed</p>	07/13/2016

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K 0038 SS=E Bldg. 01	<p>Administrator acknowledge and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 doors to the kitchen from the dining room was provided with a self-closing device causing the door to automatically close and latch into the door frame. This deficient practice could affect 40 residents in the main dining room.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Administrator on 06/13/16 at 11:50 a.m., the door from the dining room to the kitchen service side did self-close but failed to latch into the frame due to the door sticking to the frame. Based on interview, this was acknowledged by the Administrator at the time of observation.</p> <p>3.1-19(b)</p> <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 Based on observation and interview, the facility failed to ensure 1 of 8 facility exit</p>			K 0038	<p>penetrations and pipe containing wires in the 400 hall mechanical room were sealed. The door from the dining room to the kitchen was adjusted and fixed to close and latch.</p> <p><i>To ensure the deficient practice does not recur, the monitoring system established is:</i> The maintenance director or designee will perform monthly checks on doors no latching correctly with results forwarded to the facility performance improvement committee for further evaluation or resolution. The maintenance director or designee will perform quarterly audits for any unsealed penetrations. The results will be forwarded to the facility performance improvement committee for further evaluation or resolution.</p> <p>It is the practice of this facility to ensure the highest quality of care is afforded our residents.</p>		07/13/2016

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K 0046 SS=C Bldg. 01	<p>discharge paths was readily accessible at all times. This deficient practice could affect 21 residents in the 300 hall exiting in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Administrator on 06/13/16 at 12:50 p.m., the 300 hall exit door required excessive force to get the door opened after the magnetic lock was released. Based on an interview at the time of observation, it took Administrator a couple of kicks to open the door and said the door was sticking to the door frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.</p>		<p>Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> No residents affected by the deficient practice. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> No residents affected by the deficient practice. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> The 300 hall exit door was adjusted and fixed to open correctly. An audit was done on all exit doors to see if they opened correctly without any excessive force. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> The maintenance director or designee will perform monthly checks on all exit doors to make sure they are operating correctly with results forwarded to the facility performance improvement committee for further evaluation or resolution.</p>		

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	<p>Based on observation and interview, the facility failed to ensure proper documentation was available for 9 of 9 emergency light fixtures for the 30 second monthly test in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Administrator on 06/13/16 at 11:00 a.m., the monthly maintenance log showed there was a 30 second monthly test conducted for the facility's emergency lighting, but the documentation did not state which lights were inspected or where the lights were located. Based on an interview during record review, the Administrator acknowledged there was no detailed list of a 30 second monthly test for all battery emergency lighting.</p> <p>3.1-19(b)</p>	K 0046	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i> No residents affected by the deficient practice. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> No residents affected by the deficient practice. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> The form has been updated to reflect the number of battery operated emergency lights and how long they were tested. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> The maintenance director or designee will perform monthly checks and write on updated form regarding the battery operated emergency lighting with results forwarded to the facility performance improvement committee for further evaluation or resolution.</p>	07/13/2016	

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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 0050 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills for third shift at unexpected times for 4 of 4 quarters. This deficient practice affects all residents.</p> <p>Findings include:</p> <p>Based on record review of the "TELS Fire Drill Record" with the Administrator on 06/13/16 between 09:50 a.m. and 10:23 a.m., all third shift fire drills took place between 10:30 p.m. and 12:30 a.m. for the last four quarters. Based on interview, this was confirmed by the Administrator at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p>	K 0050	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i></p> <p>No residents affected by the deficient practice. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i></p> <p>No residents affected by the deficient practice. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i></p> <p>Maintenance director was in-serviced on the different times for the third shift fire drills. <i>To ensure the deficient practice does not recur, the monitoring</i></p>	07/13/2016

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K 0066 SS=F Bldg. 01	<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 Based on observation and interview, the facility failed to ensure 1 of 1 approved receptacle was provided for the disposal of cigarette butts and a container with a self-closing trash receptacle was provided to empty ashtrays only. This deficient</p>	K 0066	<p><i>system established is:</i> The Executive Director or designee will perform monthly checks on all fire drills to make sure they are being done correctly with results forwarded to the facility performance improvement committee for further evaluation or resolution.</p> <p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been</i></p>	07/13/2016

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K 0144 SS=C Bldg. 01	<p>practice could affect up to all residents using the main entrance.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Administrator on 06/13/16 at 1:10 p.m., near the front entrance there was a trash can with an open ash tray on top. There were at least ten cigarette butts in the ash tray. Based on interview at the time of observation, the Administrator acknowledged the ash tray on top of the trash can and the lack of a metal container with a self-closing covered receptacle to empty ashtrays and/or a proper longneck receptacle for the disposal of cigarette butts.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 generators in proper working order. NFPA 110, The Standard for Emergency and Standby Power Systems, Section 6-3.1, states the emergency power supply</p>			K 0144	<p><i>affected by the deficient practice was:</i> No residents affected by the deficient practice. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> No residents affected by the deficient practice. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> A new trash can and a new longneck receptacle were purchased and placed near the front entrance. The old trash can was removed and disposed of. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> All other exits that contain a trash can and longneck receptacle are in compliance so no need for further monitoring.</p> <p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: <i>The corrective action taken for the residents found to have been</i></p>		07/13/2016

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K 0147 SS=E Bldg. 01	<p>system (EPSS) shall be maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. NFPA 110, Section 6-4.7 states, the routine maintenance and operational testing program shall be overseen by a properly instructed individual. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Administrator on 06/13/16 at 1:03 p.m., on the generator annunciator panel the "E-stop Engaged" trouble light was illuminated. When the E-stop was checked, it was not engaged. Based on an interview at the time of observation, the Administrator did not know why the "E-stop Engaged" trouble light was illuminated.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1</p> <p>Based on observation and interview, the facility failed to ensure 6 of 6 flexible cords were not used as a substitute for fixed wiring to provide power equipment</p>	K 0147	<p><i>affected by the deficient practice was:</i> No residents affected by the deficient practice. <i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i> No residents affected by the deficient practice. <i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i> A quote for a new annunciator panel was obtained and new panel ordered. This will be replaced once the part is received. <i>To ensure the deficient practice does not recur, the monitoring system established is:</i> The maintenance director or designee will perform monthly checks to make sure annunciator panel is working correctly with results forwarded to the facility performance improvement committee for further evaluation or resolution.</p> <p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:</p>	07/13/2016			

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	<p>with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, 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 up to 40 residents in 4 of 6 smoke compartments</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Administrator on 06/13/16 between 11:30 a.m. and 2:00 p.m., a refrigerator was plugged into an extension cord power strip in rooms 107, 109, 206, 306, and 313, furthermore, in the admissions office a refrigerator was plugged in to a multi-plug adaptor. Based on interview, the Administrator acknowledged the extension cord power strip and multi-plug adaptor at the time of observations.</p> <p>3.1-19(b)</p>		<p><i>The corrective action taken for the residents found to have been affected by the deficient practice was:</i></p> <p>The refrigerators in rooms 107, 109, 206, 306, and 313 were unplugged and plugged into the wall outlet the same day.</p> <p><i>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</i></p> <p>A facility wide audit of all resident rooms and offices was completed to make sure no other refrigerators were plugged into a power strip.</p> <p><i>The measures put into place and a systemic change made to ensure the deficient practice does not recur is:</i></p> <p>The refrigerator in the admissions office was unplugged from the multi-plug adaptor and plugged into the wall outlet.</p> <p><i>To ensure the deficient practice does not recur, the monitoring system established is:</i></p> <p>A performance indicator has been established which will evaluate compliance with multi-plug adaptors, and power strips. The maintenance director or designee will complete the indicator weekly for the first month and then monthly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution.</p>		