STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING	(X3) DATE SURVEY COMPLETED 03/27/2014
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321	

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K030000	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). Survey Date: 03/27/14 Facility Number: 000056 Provider Number: 155131 AIM Number: 100289450 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Munster Med-Inn 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 18, New Health Care Occupancies and 410 IAC 16.2. This six story facility with a basement was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and in spaces open to the corridors. Battery operated smoke	K030000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	detectors are installed in all resident rooms. The facility has a capacity of 225 and had a census of 211 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/01/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K030018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 1. Based on observation and interview, the facility failed to ensure doors protecting corridor openings on 1 of 6 floors could automatically latch into the door frame. This deficient practice affects staff, visitors and 10 or more residents on the ground floor. Findings include: Based on observation with the maintenance consultant on 03/27/14 between 11:30 a.m. and 3:30 p.m., double doors separating the administration office from the exit corridor and two doors between the kitchen and the main dining room were equipped with deadbolt latches. The main dining room was open to the corridor. Unless the deadbolts were manually engaged, the doors could not hold the doors tightly in their door frames. The maintenance consultant acknowledged at the time of observations, the doors did not latch automatically to secure the doors tightly into their door frames.	K030018	K-18 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draftor may be discussed in this response and Plan of Correction.In direct response to the five questions listed on page one of the letter to this facility dated April 2, 2014, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The facility will remove the deadbolt on the door to the Administration offices. The facility will remove the deadbolt from the doors leading to the main dining room from the kitchen. The facility will remove the slide bolt latch from the 2nd floor Social Service office. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	04/26/2014

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure a door protecting a corridor opening on 1 of 5 sleeping room floors was equipped with a positive latch. This deficient practice affects staff, visitors and 10 or more residents on the second floor. Findings include: Based on observation with the maintenance consultant on 03/27/14 at 2:10 p.m., the social services office door was equipped with a slide bolt latch which required manual latching to secure the door. The maintenance consultant acknowledged the latch at the time of observation. 3.1-19(b)		action(s) will be taken;A facility walk through will be completed by Building Maintenance staff to identify any other doors protecting corridor openings with deadbolt locks. In the event a like-circumstance is identified, the deadbolt will be replaced with a positive latch mechanism.A facility walk through will be completed by Building Maintenance staff to identify any other doors protecting a corridor opening with slide bolt latches.In the event a like-circumstance is identified, the slide bolts latches will be removed. 3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;The facility is committed to notifying all contractors of the requirments to ensure appropriate locking mechanisms are in place in the event that any new doors are installed in the facility. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quailty assurance program will be put into place;The facility Building Manager will be responsible to perform inspection on a quarterly basis of randomly selected doors within the facility to ensure appropriate lockings mechanisms are in place. The findings of these inspections will be reported to the Safety Committee on a quarterly basis	

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			for a minimum of 2 quarters. 5. By what date the systemic changes will be completed. April 26, 2014	

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K030021 SS=E	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: a) the required manual fire alarm system; 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 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 3 of 15 doors to basement level hazardous areas such as a storage room larger than 50 square feet and a maintenance shop were held open only by devices which would allow the doors to close upon activation of the fire alarm system. This deficient practice could affect 10 or more staff, 10 or more visitors to the basement class room, and any residents on the basement level. Findings include: Based on observation with the maintenance consultant on 03/27/14 between 11:30 a.m. and 3:30 p.m., self closing corridor doors to the basement level maintenance shop, and two general storage rooms for combustible materials	K030021	K-21 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draftor may be discussed in this response and Plan of Correction.In direct response to the five questions listed on page one of the letter to this facility dated April 2, 2014, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;The surveyor cited bungee cords were removed upon observation. 2. How other residents having the	04/26/2014

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	were tied open with bungee cords and/or cords. The storage rooms were each larger than 200 square feet. The maintenance consultant acknowledged at the time of observations, the doors would not automatically close when the fire alarm was activated. 3.1-19		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;A facility walk through will be completed by facility staff to identify any other self closing doors held open with bungee cords.In the event a like-circumstance is identified, the bungee cords will be removed. 3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;The facility will conduct in-servicing with staff addressing the requirement to avoid using bungee cords to hold open facility doors. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quailty assurance program will be put into place;The facility Environmental Services Supervisor will complete walking rounds in the facility on a weeklyy basis to observe for compliance with requirement to avoid using bungee cords to hold open facility doors, data will be compiled and findings will be reported by the Enviornmental Services Supervisor to the Quality Assurance Committee on a quarterly basis for a minimum of 2 quarters. 5. By what date the systemic changes will be completed. April 26, 2014	

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K030025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-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 in approved 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. 18.3.7.3, 18.3.7.5, 18.1.6.3 Based on observation and interview, the facility failed to ensure openings through ceiling smoke barriers on 2 of 6 floors were sealed with a material to provide the one hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire 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 visitors, staff and 20 or more residents on the second and third floor. Findings include: a. Based on observation with the maintenance consultant on 03/27/14 at 1:40 p.m., the gap around the pipe above	K030025	K-25 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draftor may be discussed in this response and Plan of Correction.In direct response to the five questions listed on page one of the letter to this facility dated April 2, 2014, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;The facility will remove the identified foam and replace with a fire-rated material in the 2nd and 3rd floor janitors closets.The facility will install an approved access panel in the 2nd floor janitors closet.	04/26/2014

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	the mop sink in the third floor janitor's closet was filled with an expandable foam. The maintenance consultant agreed at the time of observation, the penetration had not been properly sealed. b. Based on observation with the maintenance consultant on 03/27/14 at 2:05 p.m., a 12 inch by 12 inch cutout in the ceiling of the second floor janitor's closet ceiling was unsealed into the interstitial space above. In addition, a two inch pipe penetrating the ceiling above the mop sink were unsealed leaving a one inch gap. The maintenance consultant acknowledged at the time of observation, these openings should have been sealed. 3.1-19(b)		2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;A facility walk through will be completed by Building Maintenance staff to identify any other gaps to verify approved UL rated materials/systems have been used to close penetrations.In the event a like-circumstance is identified, fire-rated material will be used to properly seal gaps.A facility walk through will be completed by the Building Maintenance staff to identify any other improper ceiling openings.In the event a like-circumstance is identified, appropriate measures will be taken to close openings. 3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;The facility will notify all contractors working within the facility that any work that causing penetrations will require that penetrations must be properly sealed using UL approved materials/systems. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quailty assurance program will be put into place;The facility Building Manager/designee will be responsible to complete walking rounds in various areas of the facility on a quarterly basis to	

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			ensure all ceiling openings and any identified gaps are properly sealed using UL approved materials/systems. The facility Building Manager will compile date from rounds and will report findings to the Safety Committee on a quarterly basis for a minimum of 2 quarters. 5. By what date the systemic changes will be completed. April 26, 2014	

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K030029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to provide automatic closers for doors providing access to 6 of 15 basement level hazardous areas such as combustible materials storage rooms larger than 50 square feet and laundries larger than 100 square feet. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect 10 or more staff, 10 or more visitors to the basement class room, and any residents on the basement level. Findings include: Based on observation with the maintenance consultant on 03/27/14 between 11:30 a.m. and 3:30 p.m., doors separating the basement trash collection room, laundry room, laundry clean storage room, laundry collection cart storage room, dietary storage room and central nursing supply storage room (two doors) each larger than 50 square feet,	K030029	K-29 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draftor may be discussed in this response and Plan of Correction.In direct response to the five questions listed on page one of the letter to this facility dated April 2, 2014, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;The facility will install automatic closers for the doors separating the basement trash collection room, the laundry room, the laundry clean storage room, the laundry collection cart storage room, the dietary storage room and the two doors in the central nursing supply room. 2. How other residents having the potential to be affected by the same deficient practice will be	04/26/2014

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	had no self closing devices. The rooms stored paper, plastic and cardboard wrapped supplies, linens and other miscellaneous materials. The maintenance consultant acknowledged at the time of observations, these doors lacked self closers. 3.1-19(b)		identified and what corrective action(s) will be taken;A facility walk through will be completed by Building Maintenance staff to identify any other instances of doors requiring automatic closers that do not have them provided to ensure compliance with NFPA Life Safety Code Standards.Any other like-circumstances identified will result in automatic closers being installed. 3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;Doors will be randomly selected for monthly inspection by the facility Building Manager to ensure closers are properly affixed and operational. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quailty assurance program will be put into place;The facility Building Manager will compile findings and report to the Safety Committee on a quarterly basis for a minimum of 2 quarters. 5. By what date the systemic changes will be completed. April 26, 2014	

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K030044 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 3 ground floor fire door sets was arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect visitors, staff, and 10 or more residents on the ground floor. Findings include: Based on observation with the maintenance consultant on 03/27/14 at 2:55 p.m., the fire door set near the ground floor general store was tested twice. One door in the fire door set failed to latch each time the doors were released from their magnets and allowed to close. The maintenance consultant acknowledged at the time of observation, the latching mechanism needed "adjustment."	K030044	K-44 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draftor may be discussed in this response and Plan of Correction.In direct response to the five questions listed on page one of the letter to this facility dated April 2, 2014, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;The ground floor fire doors near the general store will be adjusted to ensure proper closure. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;A facility walk through will be completed by Building Maintenance staff to test all fire doors for proper closure.In the event a like-circumstance is identified, steps will be taken to make all necessary adjustments to ensure proper closure. 3. What measure will be put into	04/26/2014

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	3.1-19(b)		place or what systemic changes will be made to ensure that the deficient practice does not recur;The facility has implemented a weekly fire door inspection process. The Building Maintenance staff will be required, on a monthly basis, to inspect all fire doorsto verify proper closure. The facility Building Maintenance Staff will be in-serviced on this process. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quailty assurance program will be put into place;The facility Building Manager/designee will compile data from the monthly inspections and present findings to the Quality Assurance Committee, on a quarterly basis,for a minimum of 2 quarters. 5. By what date the systemic changes will be completed. April 26, 2014	

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K030050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 2 of the last 4 quarters and provided evidence of staff participation in training to ensure their familiarity with procedures. This deficient practice could affect all residents, staff and visitors in the event of an emergency. Findings include: Based on review of the facility's Disaster Fire Drill Critique Forms with the maintenance consultant on 03/27/14 at 3:50 p.m., there was no record of a first shift fire drill during the third quarter or a second shift during the fourth quarter of 2013. In addition, records for staff participation were missing for each of the past four quarters. The maintenance consultant explained at the time of record review, participation was documented on	K030050	K-50 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draftor may be discussed in this response and Plan of Correction.In direct response to the five questions listed on page one of the letter to this facility dated April 2, 2014, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;The facility respectfully submits that there is no retrospective corrective action to address the absence of the fire drills for the 1st shift in the 3rd quarter 2013 or 2nd shift in the 4th quarter 2013.The facility respectfully submits that there is	04/26/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING	(X3) DATE SURVEY COMPLETED 03/27/2014
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321	

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	a separate form by staff on each floor. No fire drill during the past four quarters included signature sheets of staff participation for all five floors. The maintenance consultant acknowledged at the time of record review, records were missing for all staff participation. 3.1-9(b) 3.1-51(c)		no retrospective corrective action to address the asbence of signature sheets for staff participation for all 5 floors. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;The facility Building Manager has reviewed the current fire drill schedule and has verified that fire drills have been conducted per schedule. We are confident compliance with documentation of staff participation will be achieved, moving forward, through education and an improved process. 3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;The facility staff will be in-serviced on the necessity to complete the facility Fire Drill Critique form which requires all staff sign to acknowledge their participation.It will be the responsibility of the Building Manager/designee to gather all floors forms. A Fire Drill Critique Form checklist has been implemented to document the date and time of drill and the receipt of necessary forms to ensure compliance.The Building Maintenance staff will be in-serviced on the designated schedule for each fire drill for the remainder of the year to ensure the facility is in compliance with	

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			requirements. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quailty assurance program will be put into place;On a monthly basis, the facility Building Manager will be responsible to compile data regarding Fire Drill testing and staff participation and present findings to the Quality Assurance Committee, on a quarterly basis, for a minimum of 2 quarters. 5. By what date the systemic changes will be completed. April 26, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING	X3) DATE SURVEY COMPLETED
	155131		03/27/2014

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K030051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6 Based on observation and interview, the facility failed to ensure a smoke detector connected to the fire alarm system on 1 of 5 floors was properly separated from an air supply. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect visitors, staff, and 20 or more residents in the main dining room on the ground floor. Findings include: Based on observation with the maintenance consultant on 03/27/14 at	K030051	K-51 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draftor may be discussed in this response and Plan of Correction.In direct response to the five questions listed on page one of the letter to this facility dated April 2, 2014, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;The surveyor identified	04/26/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING	(X3) DATE SURVEY COMPLETED 03/27/2014
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	3:00 p.m., one smoke detector in the main dining room on the ground floor was located 12 inches from the air supply vent. The maintenance consultant acknowledged at the time of observation, the proximity of the smoke detector to the air flow could interfere with smoke detector function. 3.1-19(b)		smoke detector will be moved to ensure appropriate placement; OR the air supply will be affixed with approved deflectors to avoid interferrance with smoke detector. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;A facility walk through will be completed to verify proper placement of all smoke detectors.In the event a like-circumstance is identified, steps will be taken to relocate smoke detectors or apply deflectors where appropriate. 3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;The facility is committed to notifying contractors of the requirement to ensure appropriate distance for the installation of any future smoke detectors. The facility Building Manager will visualize all smoke detectors on a quarterly basis to ensure proper installation. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quailty assurance program will be put into place;The facility Building Manager will compile data from inspections and report findings to the Safety Committee on a quarterly basis for a minimum of 2 quarters. 5. By what date the systemic	

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			changes will be completed. April 26, 2014	

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K030062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observation and interview, the facility failed to ensure piping for 1 of 1 automatic sprinkler systems was maintained free of external loads. NFPA 25, 2-2.2.2 requires sprinkler piping shall be not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice affects visitors, staff and 10 or more residents on the first floor. Findings include: Based on observation with the maintenance consultant on 03/27/14 at 12:40 p.m., a sprinkler pipe above the suspended ceiling near the center first floor stairway door was used as a hanger to support conduit. The maintenance consultant acknowledged at the time of observation, the conduit was supported by the sprinkler pipe. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure sprinkler heads providing protection for 1 of 3	K030062	K-62 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draftor may be discussed in this response and Plan of Correction.In direct response to the five questions listed on page one of the letter to this facility dated April 2, 2014, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;The conduit noted by the surveyor will be properly secured removing connection to the sprinkler pipe near the center stairwell.An escutcheon will be placed for the sprinkler head in both the 4th floor clean utility room and 4th floor med room. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;A facility walk through will be completed to	04/26/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING	(X3) DATE SURVEY COMPLETED 03/27/2014
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	fourth floor smoke compartments were maintained. This deficient practice could affect staff, visitors and 10 or more residents on the fourth floor. Findings include: Based on observation with the maintenance consultant on 03/27/14 between 11:30 p.m. and 3:30 p.m., a sprinkler head escutcheon was missing in the fourth floor clean utility/oxygen transfer room and the fourth floor medicine room leaving 1/4 inch and 1/2 inch annular gaps into interstitial spaces above the rooms. The maintenance consultant acknowledged at the time of observation, the sprinkler escutcheons were missing. 3.1-19(b)		inspect sprinkler pipe to ensure pipes are free of conduit being supported.In the event a like-circumstance is identified, measures will be taken to remove conduit.A facility walk through will be completed to verify all sprinkler heads are appropriately fitted with an escutcheon.In the event a like-circumstance is identified, measures will be taken to fit identified sprinkler heads with an escutcheon. 3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;The facility Building Maintenance Staff will be in-serviced on the requirement to ensure sprinkler pipes are free of any form of interference.The facility will complete quarterly walking rounds and visualize sprinkler heads to ensure the presence of an approved escutcheon. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quailty assurance program will be put into place;On a quarterly basis, the Building Manager/designee will be responsible to inspect sprinkler pipes throughout the facility to ensure they are free of interference. The findings of these inspections will be reported to the Safety Committee on a quarterly basis.The facility Building Manager will compile	

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			data from sprinkler head walking rounds and report findings to the Safety Committee on a quarterly basis for a minimum of 2 quarters. 5. By what date the systemic changes will be completed. April 26, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING	(X3) DATE SURVEY COMPLETED 03/27/2014
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K030068 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundries was provided with intake combustion air from the outside for four gas fueled commercial dryers. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for 6 or more staff and any visitors or residents in the basement laundry. Findings include: Based on observation with the maintenance consultant on 03/27/14 at 3:30 p.m., a fresh air intake was not provided for the four commercial gas fueled dryers in the basement laundry. The maintenance consultant acknowledged the condition at the time of observation, and said a vent in the wall behind the dryers had been sealed after a flood. 3.1-19(b)	K030068	K-68 EXTENSION REQUEST (See attached Waiver Request) Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated April 2, 2014, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The facility will arrange for an appropriate contractor to assess laundry room and provide quote to install a fresh air intake. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; A facility walk through has been completed, there have been no other like-circumstances identified. 3. What measure will be put into place or what systemic changes will be made to ensure	07/26/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING	(X3) DATE SURVEY COMPLETED 03/27/2014
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321	

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			that the deficient practice does not recur; The facility Building Maintenance staff will perform monthly inspections of the fresh air intake (upon installation) in the laundry room to ensure proper function. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quailty assurance program will be put into place; The Building Manager will be compile data from the monthly inspections and report, on a quarterly basis, the findings to the Quality Assurance Committee for a minimum of 2 quarters. 5. By what date the systemic changes will be completed. July 26, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING	(X3) DATE SURVEY COMPLETED 03/27/2014
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K030074 SS=E	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. 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. 18.7.5.1, 1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4, 18.7.5.3 Based on observation, interview, and record review; the facility failed to ensure decorative hanging curtains were rendered flame resistant on 2 of 6 floors. LSC 19.7.5.1 requires draperies, curtains, including cubicle curtains, 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 20 or more residents on the second and ground	K030074	K-74 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draftor may be discussed in this response and Plan of Correction.In direct response to the five questions listed on page one of the letter to this facility dated April 2, 2014, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	04/26/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING	X3) DATE SURVEY COMPLETED 03/27/2014
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321	

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	floors. Findings include: a. Based on observation with the maintenance consultant on 03/27/14 between 11:30 a.m. and 3:30 p.m., a curtain hanging over the opening to an elevator in the fifth floor assisted dining room, and the heavy drapery hanging floor to ceiling in the ground floor theater each lacked evidence indicating their flame resistance in accordance with NFPA 701. The maintenance consultant acknowledged at the time of observations, there was no evidence the materials were flame resistant. A review of flame spread rating document provided during record review on 03/27/14 at 4:05 p.m., did not include ratings for these loosely hanging materials. b. Based on observation with the maintenance consultant on 03/27/14 between 11:30 a.m. and 3:30 p.m., decorative window scarves and valances on the second floor in resident rooms and corridors lacked evidence indicating their flame resistance in accordance with NFPA 701. The maintenance consultant acknowledged at the time of observations, there was no evidence the materials were flame resistant. A review of flame spread rating document provided during record review on 03/27/14 at 4:05		practice;The surveyor identified drape in the 5th floor even hall dining room will be removed.The facility has obtained flame spread rating details for the drapes hung in the ground floor theater.The facility will remove the surveyor noted decorative window scarves and valances on 2nd floor. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;The facility will verify the presence of necessary flame spread rating for decorative window scarves and drapes in the facility.In the event a like-circumstance is identified, appropriate steps will be taken to obtain necessary flame spread documentation. 3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;Staff responsible for facility decor will be in-serviced on the requirement to obtain flame spread rating documentation for all window treatments being ordered for installation within the facility. Approval from Safety Committee will be required prior to ordering of any new window treatments. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quailty assurance program will be put into place;The facility Safety Officer will provide	

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	p.m., did not include ratings for these window treatments. 3.1-19(b)		a quarterly report to the Safety Committee any decoration efforts within the facilty and provide documentation of the presence of flame spread rating for window treatments. 5. By what date the systemic changes will be completed. April 26, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING	(X3) DATE SURVEY COMPLETED 03/27/2014
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321	

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K030143 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 1. Based on observation and interview, the facility failed to ensure 5 of 5 oxygen transfer sites were posted with signs indicating oxygen transferring was taking place, were provided with continuous mechanical ventilation to the outside, had ceramic or concrete flooring and were separated from any portion of the facility wherein residents are housed by a fire barrier of 1 hour fire resistive construction. This deficient practice affects staff, visitors and residents on all sleeping room floors. Findings include: Based on observation with the maintenance consultant on 03/27/14 between 11:30 a.m. and 3:30 p.m.,	K030143	K-143Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draftor may be discussed in this response and Plan of Correction.In direct response to the five questions listed on page one of the letter to this facility dated April 2, 2014, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;The facility will obtain fire rating information for the door to	04/26/2014

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NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321	

(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
	oxygen transfer from liquid oxygen supply containers into portable oxygen tanks was done in the fifth floor oxygen supply and transfer room, and in the first, second, third, and fourth floor clean utility storage rooms. The fifth floor oxygen transfer room corridor access door had no fire rating and lacked a self closer. Utility rooms on the first, second and third floors were used for the transfer of oxygen as evidenced by oxygen transfer instructional signs, complete with diagrams on one wall and an available liquid supply oxygen tank. Doors separating these rooms from adjacent corridors were not fire rated, the rooms were not equipped with continuous mechanical ventilation to the outside, the rooms were used for the collection and storage of other combustible materials, and the floors were covered with a material other than concrete or ceramic tile. The suspended ceilings were not rated and one or two penetrations of concrete walls above the suspended ceilings were unsealed leaving gaps of one half inch into adjacent spaces. The maintenance consultant agreed at the time of observations, these rooms were not designed for the purpose of transferring liquid oxygen. 3.1-19(b)		the 5th floor oxygen room.The facility will fit the 5th floor oxygen room door with an approved self closer.The facility will remove liquid oxygen and transfilling equipment and signage from the 1st through 4th floor clean utility rooms. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;A facility walk through has been completed and there are no other identified areas where liquid oxygen or transfilling equipment is stored. 3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;Facility staff will be in-serviced on the proper storage of liquid oxygen and transfilling equipment. Staff will be required to complete this task in the 5th floor oxygen room. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quailty assurance program will be put into place;On a weekly basis, facility Administration will complete walking rounds to ensure compliance with proper storage of liquid oxygen. Findings from weekly walking rounds will bereported, on a quarterly basis, to the Quality Assurance Committee for a minimum of 2 quarters.	

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	2. Based on observation and interview, the facility failed to ensure electrical switches and receptacles in 4 of 5 oxygen transfer rooms were located at least five feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage. This deficient practice could affect staff, visitors, and 40 or more residents on the first, second, third and fourth floors. Findings include: Based on observation with the maintenance consultant on 03/27/14 between 11:30 a.m. and 3:30 p.m., oxygen transfer from liquid oxygen supply containers into portable oxygen tanks occurred in the first, second, third, and fourth floor clean utility storage rooms. Light switches were located 48 and 42 inches above the floor and an electrical outlet was located 12 inches above the floor in each of the rooms. The maintenance consultant acknowledged at the time of observations, the location of these electrical features were less than the 60 inch minimum allowable height.		5. By what date the systemic changes will be completed. April 26, 2014	

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	3.1-19(b)			

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K030144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature.	K030144	K-144 - EXTENSION REQUEST (See attached Waiver Request) Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated April 2, 2014, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The facility is committed to seeking the appropriate contractor to install a remote annunciator panel for the facility emergency generator. The facility respectfully submits there is no retrospective corrective action to address the lack of a monthly generator load test documentation of percentage of load carried as identified by the surveyor. The facility respectfully submits there is no retrospective corrective action to address the	06/26/2014

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	4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice affects all visitors, staff and residents. Findings include: Based on observation with the maintenance consultant on 03/27/14 between 11:30 a.m. and 3:30 p.m., an ancillary remote alarm annunciator for the emergency generator was not found. The generator operator was interviewed on 03/27/14 at 4:10 p.m., and he confirmed there was no remote annunciator for the emergency generator and the annunciator alarm on the generator could not be heard unless there was someone in the generator room. 3.1-19(b)		lack of documentation of the duration of transfer time during generator testings as identified by the surveyor. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The facility is supplied by a sole emergency generator. The Building Manager has verified current compliance with the completion of monthly generator testings and the presence of necessary documentation of percentage of load carried during testings. 3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The facility Building Maintenance staff performs routine emergency generator testings. The function of the remote annunciator panel (upon installation) will be verified with all routine testings. All routine generator testing documentation forms will be revised to include ensuring proper function of the remote annunicator panel. All Building Maintenance staff will be in-serviced on the revised generator testing requirements to now include checking function of remote annunciator panel. All Building Maintenance staff will be in-serviced on the requirement to document the percentage of load carried and for the duration of time for transfer for all scheduled generator testings. 4. How the	

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	2. Based on record review and interview, the facility failed to ensure monthly generator load test records for 1 of 1 emergency generators included complete information for testing using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly		corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quailty assurance program will be put into place; The facility Building Manager is responsible for the collection of all generator testing documentation. The facility Building Manager will complie data from the routine generator testing documents and report findings to the Quality Assurance Committee on a quarterly basis for a minimum of 2 quarters. 5. By what date the systemic changes will be completed. June 26, 2014	

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	maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the facility Emergency Generator Run Logs with the maintenance consultant on 03/27/14 at 4:15 p.m., the record failed to include the percent load carried during each test or information regarding the minimum loading and exhaust temperatures during the tests. The maintenance consultant acknowledged at the time of record review this information was not recorded. He said he did not know the percent load on the generator during testing. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure monthly generator load test records for 1 of 1 emergency generators included complete information to evidence the generator was capable of automatically connecting to the load within 10 seconds in the event of normal power failure. NFPA 101, 4.6.12 requires equipment required for compliance with the provisions of the Code shall be continuously maintained. NFPA 99,			

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	requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. NFPA 99, 3-6.3.1.2 requires the emergency system to be arranged so that, in the event of failure of the normal power source, the alternate source of power will automatically connect to the load within 10 seconds. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the maintenance consultant and generator operator on 03/27/14 at 4:10 p.m., documentation for load testing the emergency generator did not include the time it took to transfer the load during the tests. The generator operator was interviewed the time of record review. He confirmed all documentation, including the transfer time and readings during each of three phases had not been documented during each load test. 3.1-19(b)			

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K030147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 1. Based on observation and interview, the facility failed to ensure 4 of 4 flexible cords were not used as a substitute for fixed wiring. 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 2 or more staff and visitors in the penthouse and staff, visitors and 20 or more residents on the first and second floors. Findings include: a. Based on observations with the maintenance consultant on 03/27/14 at 12:45 p.m., a power strip and extension cord were piggybacked in the penthouse equipment room to power a bank of television service equipment. The maintenance consultant acknowledged the arrangement to power the equipment at the time of observation. b. Based on observations with the maintenance consultant on 03/27/14 between 11:30 a.m. and 3:30 p.m., power strip extension cords were used to supply power to a refrigerator in the storage	K030147	K-147 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draftor may be discussed in this response and Plan of Correction.In direct response to the five questions listed on page one of the letter to this facility dated April 2, 2014, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;The facility will remove all identified power strip/extension cords as identified by the surveyor in the penthouse, 2nd floor fax room, and 1st floor nourishment room.The facility will cover junction boxes as identified by the surveyor in the dock area and generator room. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;A facility walk through will be completed to ensure compliance with approved	04/26/2014

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	room across from the second floor nurses' station and two refrigerators in the first floor nourishment room. The maintenance consultant acknowledged the arrangement to power the equipment at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 3 of 3 electrical wiring connections were maintained in a safe operating condition which included junction boxes. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect 2 or more visitors and staff in the dock heating and generator rooms. Findings include: Based on observations with the maintenance consultant on 03/27/14 between at 11:30 a.m. and 3:40 p.m., a junction box was uncovered at the ceiling in the dock heating equipment room, and a junction box on the ceiling and wall of the generator room were each uncovered. The maintenance consultant acknowledged at the time of observations, the boxes should have been covered.		power sources.In the event a like-circumstance is identified, any inappropriate power supply will be removed.A facility walk through will be completed to ensure compliance with proper covering of junction boxes.In the event a like-circumstance is identified, appropriate steps will be taken to properly cover identified junction boxes. 3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;Facility staff will be in-serviced on the requirement to avoid the use of power strips/extension cords.The facility Building Maintenance staff and contractors will be notified of the requirement to ensure any newly installed junction box is appropriately covered. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quailty assurance program will be put into place;The facility Environmental Services Supervisor will perform weekly walking rounds and will make observations of power sources to ensure compliance. Findings from walking rounds will be reported by the Environmental Services Supervisor to the Quality Assurance Committee on a quarterly basis for a minimum of 2 quarters.The facility Building Manager will be responsible to perform inspections of the facility	

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	3.1-19(b)		on a quarterly basis to ensure compliance with appropriate junction box covering. The findings will be reported to the Safety Committee on a quarterly basis for a minimum of 2 quarters. 5. By what date the systemic changes will be completed. April 26, 2014	