

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155787	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2013
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NAME OF PROVIDER OR SUPPLIER INDIANA VETERANS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3851 N RIVER RD WEST LAFAYETTE, IN 47906
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Dates: 04/16/13 and 04/17/13</p> <p>Facility Number: 001134 Provider Number: 155787 AIM Number: 200817200</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Indiana Veterans Home 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 facility was located in three buildings determined to be of Type I (443) construction identified as Mitchell Hall (3 story), Pyle Hall (3 story) and MacArthur Hall (4 story). The buildings were surveyed as one since they were all constructed prior to March 1, 2003. The</p>	K010000	<p>Preparation and/or execution of the Plan of Correction in general, or these Corrective actions in particular, does not constitute an admission or agreement by this facility of the truth of the facts alleged or the conclusions set forth in this statement of deficiencies. This Plan of Correction and specific actions are prepared and/or executed in compliance with ISDH Nursing Home guidelines. This Plan of Correction is not meant to establish a standard of care, contract, obligation or position and the Indiana Veterans' Home reserves all rights to raise all possible contentions and defenses to the allegations and conclusions made by the State Department of Health</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>buildings were fully sprinklered. MacArthur and Pyle Halls have basements. There is a partial basement under the mechanical room on Mitchell Hall. The facility has a fire alarm system with hardwired smoke detectors in corridors, common areas and in resident rooms. The facility has the capacity for 197 and a census of 170 residents.</p> <p>All areas where residents have customary access were sprinklered with the exceptions cited at K56 and K9999. Areas providing facility services were sprinklered except the detached generator building, maintenance shop building, and areas cited at K56 and K9999.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/22/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>						

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors protecting corridor openings on 2 of 3 floors in two buildings could latch automatically into the door frame. This deficient practice affects staff, visitors and 50 or more residents in the Pyle basement, and Mitchell 3.</p> <p>Findings include:</p> <p>a. Based on observation with the Physical Plant Director and Safety Officer on 04/17/13 at 3:45 p.m., the corridor door to the Pyle conference room was equipped with a deadbolt lock which was the only means to secure the door in the door frame. If the lock was not engaged the door could not be held tightly in the door</p>	K010018	<p>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice? Pyle Basement Conference Room door-deadbolt lock is only means of securing door in frame Pyle 3 Linen Storage Room-Double doors do not latch automatically Mitchell 3CD Linen Room-Double doors do not latch automatically Doors will be inspected and repaired/replaced</p> <p>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? All other doors will be inspected in all buildings for same problems. A PM will be generated to do this.</p> <p>3. What measures will be put</p>	05/17/2013			

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	<p>frame.</p> <p>b. Based on observation with the Physical Plant Director and Safety Officer on 04/17/13 between 11:30 a.m. and 4:50 p.m., the double door sets protecting openings to the corridor for the Pyle 3 linen storage room and the Mitchell 3CD linen storage room each had one inactive leaf with a manual flush bolt to secure the inactive leaf into the door frame. Unless the inactive door leaf was manually latched in these door sets, neither door was secured tightly into the door frame. The Physical Plant Director acknowledged at the time of observations, each door could not latch automatically into the door frames.</p> <p>3.1-19(b)</p>		<p>into place or what systemic changes will be make to ensure that the deficient practice does not occur again?</p> <p>A PM will be entered into our system to inspect door monthly.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place?</p> <p>Audits will be done weekly for 1 month and then monthly thereafter.</p> <p>5. By what date the systemic changes will be completed?</p> <p style="text-align: right;">Comp</p> <p>leted By:</p> <p>Audits will be completed. 05/10/2013</p> <p>Quotes will be obtained for repairs. 05/10/2013</p> <p>Repairs will be completed by vendor. 05/17/2013</p> <p>Weekly audits will be done for one month. 05/17/2013</p> <p>Monthly PM will be generated to inspect all doors. 05/01/2013</p>		

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K010021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 doors to the laundry linen collection room, a hazardous area, were held open only by devices which would allow the doors to close upon activation of the fire alarm system. This deficient practice affects visitors and 20 or more residents on the the first floor of MacArthur Hall.</p> <p>Findings include:</p> <p>Based on observation with the Physical Plant Director on 04/17/13 at 11:35 a.m., the double corridor door set providing access to the main laundry linen collection room on the first floor of MacArthur Hall was not completely closed. The doors were held open because they hit one another leaving a</p>	K010021	<p>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice? Mitchell 1 Main Laundry Linen Room Doors-not closing completely leaving a two inch gap between tops of the door and door frame. We will be replacing these doors.</p> <p>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? All other doors will be inspected in all buildings for same problems.</p> <p>3. What measures will be put into place or what systemic changes will be make to ensure that the deficient practice does not occur again? A PM will be generated to inspect</p>	07/02/2013			

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	two inch gap between the tops of the doors and the door frame. The Physical Plant Director acknowledged the doors would not close at the time of observation. 3.1-19		doors monthly. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place? Audits will be done weekly for 1 month and then monthly thereafter. 5. By what date the systemic changes will be completed? We are requesting a 60 day extension to make repairs to the doors, the extension is for ensuring the parts and materials are ordered and or stock. Completed by: Audits will be completed. 05/03/2013 Requisition sent to replace doors was sent to DAPW 04/16/2013 Repairs will be made by vendor. 07/02/2013 A Service Work Order will be generated to inspect doors weekly for 1 month. 05/10/2013 A PM will be generated to inspect these doors monthly.		

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to provide automatic door closers on 4 of 40 doors providing access to hazardous area such as a kitchen and storage rooms larger than 50 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 visitors, staff and 20 or more residents in the Pyle Hall basement, and first floor of MacArthur Hall.</p> <p>Findings include:</p> <p>a. Based on observation with the Physical Plant Director and Safety Officer on 04/17/13 at 3:40 p.m., one of two doors separating the Pyle kitchen from the dining room had no self closer. The Physical Plant Director acknowledged at</p>	K010029	<p>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice? Mitchell 1 Kitchen Door to Dining Room-No door closure Mitchell 1 Lean Storage Room Door-No door closure Mitchell 1 Activities Storage Room Door-No door closure Doors will be installed with door closures</p> <p>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 door closure audit of all rooms larger than 50 square feet will be done and repaired/replaced as needed. All rooms of 50 square feet or more will be installed with a door closure.</p> <p>3. What measures will be put into place or what systemic</p>	05/17/2013
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	<p>the time of observation the door could not self close.</p> <p>b. Based on observation with the Physical Plant Director and Safety Officer on 04/17/13 between 11:30 a.m. and 4:50 p.m., a self closer was not provided on the doors for rooms larger than fifty square feet such as the ten by fourteen foot Mitchell hall activities storage room, the six by eight foot LEAN Team storage room and the twelve by twelve foot central supply storage room which contained stored materials like paper, cardboard, plastic and similar combustible materials. The Physical Plant Director acknowledged at the time of observations, these rooms met the criteria requiring doors to self close.</p> <p>3.1-19(b)</p>		<p>changes will be make to ensure that the deficient practice does not occur again? Rooms will be inspected semi-annually</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place? Audits will be done weekly for 1 month and then monthly thereafter.</p> <p>5. By what date the systemic changes will be completed? Completed by: All rooms larger than 50 square feet will be audited for door closures. 05/10/2013 Door closures will be installed.</p> <p>05/17/2013 A monthly PM will be generated to inspect doors for closures. 05/10/2013</p>		

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through exits in 3 of 3 buildings which were equipped with magnetic locks were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice affects all visitors, staff, and 157 residents housed on Mitchell, MacArthur and Pyle Halls.</p> <p>Findings include:</p> <p>Based on observations with the Physical Plant Director and Safety officer on 04/17/13 between 11:30 a.m. and 4:50 p.m., emergency exit doors were magnetically locked on Pyle 2 and 3,</p>	K010038	<p>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice? Mitchell Hall 2 and 3, MacArthur Hall 2, 3, 4 and Pyle Hall 2 and 3-Emergency Exit Doors locked. Codes will be labeled above keypad at each door.</p> <p>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? All doors will be inspected and labels will be installed.</p> <p>3. What measures will be put into place or what systemic changes will be make to ensure that the deficient practice does not occur again? Monthly PM's will be generated to inspect doors for sign location.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place? Audits will be done weekly for 1 month and then monthly thereafter.</p> <p>5. By what date the systemic changes will be completed? Completed by:</p>	05/03/2013

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	<p>MacArthur halls 2, 3, and 4, and Mitchell Hall 2 and 3. The Physical Plant Director demonstrated the locks could be overridden by inserting a specific code into the keypad located adjacent to the locked doors if the fire alarm failed to unlock the doors. A sign was posted adjacent to the Pyle 3 center stairway door instructing anyone leaving to ask an employee to provide the exit code, other wise codes were not posted. The Physical Plant Director said at the time of observations, only residents on MacArthur 2 had a diagnosis for which locks might be indicated, the code had been posted near the override keypads on other floors but were missing.</p> <p>3.1-19(b)</p>		<p>Codes placed at doors.</p> <p>04/24/2013 Weekly inspection to ensure all codes are posted.</p> <p>05/3/2013 PM to inspection monthly.</p> <p>05/3/2013</p>		

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K010051 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, 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 in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. 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 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure smoke detectors connected to the fire alarm system on 3 of 4 MacArthur Hall floors and the first and second floor of Mitchell Hall, were properly separated from an air supply. 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 40 or more residents on the basement, first, third and fourth floor levels in MacArthur Hall and the first, second, and third floors in Mitchell Hall.</p>	K010051	<p>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice? Ceiling Smoke Detectors are located 12 to 24 inches from an air supply or return in many locations, these must be three feet from air supply. Smoke Detectors will be removed from any air supply or air return locations.</p> <p>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? All Smoke Detectors in all buildings will be inspected for the</p>	05/17/2013			

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	<p>Findings include:</p> <p>Based on observation with the Physical Plant Director and Safety officer on 04/17/13 between 11:30 a.m. and 4:50 p.m., ceiling smoke detectors were located 12 to 24 inches from an air supply or return in the following locations: the supply room in the smoking room (room 125), the LEAN Team training room and the adjacent storage room, the Mitchell Hall dietary office, the 2B Mitchell Hall equipment room, the 2 B Mitchell Hall linen room (room 256), Mitchell room 254 soiled utility room, Mitchell 281 clean utility room, Mitchell room soiled utility room 371, the physical therapy treatment area, the janitor's closet near physical therapy, the physical therapy store room and office in the MacArthur building, the central supply storage room, three smoke detectors in the library, the 3 Mac treatment room, the 4 Mac nurses station, the radiology area bathroom, and the Mac basement education room. The Physical Plant Director acknowledged at the time of observations these smoke detectors were too close to air flow.</p> <p>3.1-19(b)</p>		<p>same problems and moved/or add a diffuser.</p> <p>3. What measures will be put into place or what systemic changes will be make to ensure that the deficient practice does not occur again? All smoke detectors will be reviewed and put in proper location</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place? All smoke heads will be inspected 1 st month and then reviewed yearly</p> <p>5. By what date the systemic changes will be completed? Completed by: Audit of how may smoke detectors needed to be moved. 05/07/2013 Move smoke detectors to required dimensions.</p> <p>05/17/2013 A PM will be generated to check 1 st of month then yearly thereafter. 05/17/2013</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155787		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2013	
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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 elevator equipment rooms were provided with sprinkler coverage. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect visitors staff and any of 170 residents who made use of the elevators in the three multistory buildings.</p> <p>Findings include:</p>	K010056	<p>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice? Mitchell, MacArthur and Pyle Elevator Mechanical Room do not have sprinkler coverage The Elevator Room in these buildings will be installed with sprinkler coverage.</p> <p>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? All rooms will be inspected and we will install sprinklers in elevator rooms.</p> <p>3. What measures will be put into place or what systemic changes will be make to ensure that the deficient practice does not occur again?</p>	07/02/2013			

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	<p>Based on observations with the Physical Plant Director and Safety Officer on 04/17/13 between 11:30 a.m. and 5:00 p.m., elevator equipment rooms in the Pyle, MacArthur and Mitchell buildings were not provided with sprinkler coverage. The Physical Plant Director said at the time of observations he was informed by a contractor "only the elevator pits had to be sprinklered" and that had been done, however, shunt trips for those sprinklered elevator areas had not yet been installed. The work was scheduled for 04/24/13 and 04/25/13.</p> <p>3.1-19(b)</p>		<p>Once installed a monthly PM will be generated to inspect sprinklers.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place? Audits will be done weekly for 1 month and then monthly thereafter.</p> <p>5. By what date the systemic changes will be completed? We are requesting a 60 day extension to ensure all repairs are completed by vendor. Completed by: Audits will be completed.</p> <p>05/06/2013 Quotes to be obtained.</p> <p>05/10/2013 Repairs will be completed by vendor.</p> <p>07/02/2013 A monthly PM entered into system.</p> <p>05/01/2013</p>		

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K010062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure sprinkler heads providing protection for smoke compartments in 1 of 3 buildings were maintained. This deficient practice could affect staff, visitors and 50 or more residents on Mitchell Hall.</p> <p>Findings include:</p> <p>Based on observation with the Physical Plant Director and Safety Officer on 04/17/13 between 11:30 a.m. and 4:40 p.m., sprinkler head escutcheons were missing leaving a gaps of 1/2 to 1 inch into spaces above the lay in ceiling in the Mitchell kitchen storage room closet (#140), in the first floor Mitchell lobby near the elevators, at the first floor smoke barrier between Mitchell Hall and the tunnel, and the second and third floor Mitchell Hall activities storage closets in the lounges.</p> <p>3.1-19(b)</p>	K010062	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice? Mitchell Kitchen Storage Room Closet, Mitchell 1 Lobby near elevators, Mitchell 2 and 3 Activities Storage Closets in Lounges-Sprinkler Head Escutcheons were missing, leaving gaps of 1/2 to 1 inch spaces above the lay in ceilings. All areas will have Sprinkler Head Escutcheons installed and gaps will be filled.</p> <p>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? All sprinkler heads will be inspected and adjusted as needed</p> <p>3. What measures will be put into place or what systemic changes will be make to ensure that the deficient practice does not occur again? A monthly PM will be generated to inspect for gaps in sprinkler heads</p> <p>4. How the corrective action(s) will be monitored to ensure the</p>	05/17/2013			

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			<p>deficient practice will not occur, i.e, what quality assurance program will be put into place? Monthly audits will be done by Safety to inspect.</p> <p>5. By what date the systemic changes will be completed? Completed by: Audits of all sprinklers will be completed.</p> <p>05/10/2013 Repairs all violations will be completed.</p> <p style="text-align: right;">05/17/2013</p> <p>A monthly PM will be generated to inspect for violations.</p> <p>05/17/2013</p>	

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K010067 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on record review and interview, the facility failed to ensure dampers in the ductwork serving 8 of 8 smoke compartments were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 19.5.2.1 refers to Section 9.2. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>A review of contractor Fire Safety Inspection and Test Reports for damper inspections dated 12/12/12 for the</p>	K010067	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice? Mitchell Hall, MacArthur Hall and Pyle Hall-Smoke Barrier Fire Dampers according to Inspections conducted in 10/2013 to 12/12 many not closing, could not be accessed or help open with wires or ceiling tiles. Smoke Fire Dampers in these buildings will be inspected and repaired/replaced. 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? All buildings were inspected, as a result of the inspection, a consulting architect company has been hired to perform a study on how to fix the deficiencies. 3. What measures will be put into place or what systemic changes will be make to ensure that the deficient practice does not occur again? A study will be conducted and followed once we know the outcome of the study. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not</p>	11/03/2013			

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	<p>Mitchell Hall, 08/10/12 for the MacArthur Hall and 12/14/12 for Pyle Hall was conducted with the Physical Plant Director on 04/16/13 at 1:10 p.m. The inspection and tests of smoke barrier fire dampers found:</p> <p>a. 185 dampers on Mitchell Hall; 23 did not close and 37 could not be accessed. A repair was made to 1 damper link which was found hanging and the damper closed.</p> <p>b. 375 dampers on MacArthur Hall. 63 did not close and 46 could not be accessed.</p> <p>c. 37 dampers on Pyle Hall. 8 did not close, 14 could not be accessed, and 6 had links which were "previously released and damper was held open by wire or a chunk of ceiling tile". It was noted "it has been checked and new link installed."</p> <p>The report noted problems with the accessibility of dampers, dampers found which were not noted on prints provided by the facility, a "fire damper not installed," and the possibility "there might be more dampers." The Physical Plant Director said at the time of record review, he had a service maintenance agreement for the inspection/test of 26 dampers every six months. He provided a document titled IVH-Fire Damper Repairs noting the inspection contractor had identified 599 dampers of which 103 were reported as failed and 124 reported as</p>		<p>occur, i.e, what quality assurance program will be put into place? All Dampers will be repaired, replaced or removed per study when completed. 5. By what date the systemic changes will be completed? We will be asking for a six month waiver until then until study is complete. DPW is having the study done, unknown time for this study to be completed, After review of the Study we will be requesting additional time to replace/repair or remove dampers.</p>				

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	<p>failed with no access. He said he has initiated a plan to get the number of dampers accurately identified, examined and repaired as needed. He said a consulting architect said there was some question as to whether the dampers were required. He acknowledged he had no confidence the dampers were all working.</p> <p>3.1-19(b)</p>				

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K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to maintain 2 of 6 electrical outlets in room 304 in MacArthur Hall. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects visitors, staff and 70 or more residents on MacArthur 3.</p> <p>Findings include:</p> <p>Based on observation with the Physical Plant Director on 04/17/13 at 2:40 p.m., two electric receptacles above the built in wardrobe in room 304 on MacArthur were uncovered leaving exposed wiring. The maintenance director acknowledged at the time of observations, the receptacles were not properly covered.</p> <p>3.1-19(b)</p> <p>2. 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, the National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically</p>	K010147	<p>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice? 1. MacArthur 304-two electrical receptacles above the built in wardrobe uncovered 2. Mitchell 311 and 338-extension cords were in use under head of bed 3. MacArthur Hall Laundry Storage, Recreation Department and Pyle Basement Beauty Shop-extension cords were in use All deficiencies will be repaired by 5/17/2103</p> <p>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? All rooms will be audited for similar deficiencies and repaired at that time.</p> <p>3. What measures will be put into place or what systemic changes will be make to ensure that the deficient practice does not occur again? A PM will be entered to review all rooms monthly.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality</p>	05/10/2013

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	<p>permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 10 or more residents on Mac 3, on Mac 1, and the Pyle basement level.</p> <p>Findings include:</p> <p>Based on observation with the Physical Plant Director and Safety Officer on 04/17/13 between 11:30 a.m. and 4:30 p.m., extension cords were used to supply power to equipment under the head of beds in Mitchell Rooms 311 and 338; microwaves in the laundry storage room and recreation department on MacArthur Hall; and four curling irons in the Pyle Hall beauty shop. The Physical Plant Director acknowledged at the time of observations, the power strips were used inappropriately.</p> <p>3.1-19(b)</p>		<p>assurance program will be put into place? A monthly PM will be conducted and quarterly audits by Safety</p> <p>5. By what date the systemic changes will be completed? Completed by:</p> <p>1. Receptacle install by Dave Parrish. 05/03/2013</p> <p>2. Extension cords removed by Maintenance and Safety 05/10/2013</p> <p>3. Pyle Basement Beauty Shop cords replaced by Maintenance. 05/10/2013</p> <p>4. A monthly PM entered in system. 05/01/2013</p> <p>5. Monthly audit entered in system by 05/01/2013</p>				

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K019999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by:</p> <p>Based on observation and interview, the facility failed to provide automatic sprinklers throughout the facility before July 1, 2012. This deficient practice could affect visitors, staff and 50 residents or more in the Mitchell Dining room, second and third floor of Mitchell Hall, and the X-ray room.</p>	K019999	<p>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice? Mitchell 1 Dining Room-sprinkler protection don't cover the stairway landing (West Mitchell Hall Dining Room Exit discharge to exterior exit door) MacArthur Hall Basement X-ray-no sprinkler protection Mitchell 3 and Mitchell 2AB Nurse Stations-no sprinkler protection Sprinklers will be installed in these areas as needed.</p> <p>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? All areas will be inspected and sprinkler protection will be added if required.</p> <p>3. What measures will be put into place or what systemic changes will be make to ensure that the deficient practice does not occur again? A PM will be put into place to check all areas for these deficiencies.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place? Audits will be conducted</p>	07/02/2013			

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	<p>Findings include:</p> <p>Based on observation with the Physical Plant Director and Safety Officer on 04/17/13 between 11:30 a.m. and 4:50 p.m., sprinkler protection did not cover the stairway exit landing where it converged with the west Mitchell Hall dining room exit discharge to an exterior exit door, the Mac basement X-ray room and two by three foot alcoves at the Mitchell 3 and Mitchell 2AB nurses' stations. The Physical Plant Director said at the time of observations, he was unaware sprinkler coverage was not extended to theses areas.</p> <p>3.1-19(ff)</p>		<p>Semi-Annually by Safety to ensure these areas are properly protected.</p> <p>5. By what date the systemic changes will be completed? We will be requesting a 60 day extension to ensure all repairs are completed by vendor.</p> <p>Completed by: Audits will be completed.</p> <p>05/03/2013 Quotes will be obtained by.</p> <p>05/10/2013 Repairs will be made by.</p> <p>07/02/2013 Sprinklers will be installed by vendor</p> <p>A semi-annual PM will be generated.</p> <p>05/10/2013</p>		