

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155226	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/08/2015
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NAME OF PROVIDER OR SUPPLIER  NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/08/15</p> <p>Facility Number: 000131 Provider Number: 155226 AIM Number: 100274910</p> <p>At this Life Safety Code survey, North Capitol Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This four story facility was determined to be of Type II (222) construction and fully sprinklered except for the laundry chute. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident</p>	K 0000		

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

TITLE

(X6) DATE

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

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K 0015 SS=E Bldg. 01	<p>sleeping rooms. The facility has a capacity of 123 and had a census of 109 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered.</p> <p>Quality Review completed 10/14/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to provide documentation of the flame spread rating for interior finish materials installed in 1 of over 75 rooms. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the pill dispensing room on the second floor.</p> <p>Findings include:</p>	K 0015	The Creation and submission of the Plan of Correction does not constitute and admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation.1. The wood paneling on each of the four walls from the floor to the ceiling in the pill dispensing room on the second floor has been treated with the flame retardant material.2. All residents, staff and visitors have the potential to be affected3. The	11/07/2015

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K 0018 SS=E Bldg. 01	<p>Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, wood paneling was on each of four walls from the floor to the ceiling in the pill dispensing room on the second floor. Based on interview at the time of observation, the Maintenance Director stated he was unaware of the wood paneling being treated with flame retardant material and acknowledged flame spread rating documentation was not available for review for the wood paneling in the pill dispensing room on the second floor.</p> <p>3.1-19(b)</p> <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</p>		Maintenance Director will maintain documentation of all wood paneling being treated with flame retardant materials. 4. Results will be submitted monthly at the QA Committee.5. Date of Compliance: November 7, 2015				

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	<p>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 4 of over 75 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 30 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, the following was noted:</p> <p>a. the corridor door to the first floor Housekeeping Office and the first floor Soiled Laundry Room were propped open with a door wedge.</p> <p>b. the corridor door to the third floor Oxygen Storage and Transfilling Room failed to self close and latch into the door frame because the door hit the frame on the handle side of the door preventing it from fully closing.</p> <p>c. the corridor door to Room 206 failed to close and latch into the frame because the latching mechanism was stuck in the door and failed to protrude into the latching</p>	K 0018	<p>The Creation and submission of the Plan of Correction does not constitute and admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation.1. a. The corridor door to the first floor housekeeping Office and first floor soiled Laundry room has been cleared of the door wedges b. The corridor door to the third floor Oxygen storage and Trans filling room self-closer and latch into the door frame has been repaired. c. The corridor door to room 206 latching mechanism has been repaired.2. All resident have the potential to be affected.3.The Maintenance Director will inspect and monitor daily for one month and weekly thereafter.4. A maintenance log will be used to document the inspection. All results will be submitted to the Month QA committee.5. Date of Compliance: November 7, 2015</p>	11/07/2015

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K 0020 SS=E Bldg. 01	<p>plate of the frame when closed. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned corridor doors had an impediment to closing and latching into the door frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p> <p>Based on observation and interview, the facility failed to enclose 1 of 3 vertical openings with construction having a fire resistance rating of at least two hours. LSC 8.2.5.2 requires openings shall be protected as appropriate for the fire resistance rating of the barrier. LSC 7.1.3.2.1(b) requires a two hour rating in existing buildings of four stories or more. 7.1.3.2.1(c) requires openings in separations shall be protected by fire door assemblies. NFPA 80, the Standard for Fire Doors and Fire Windows, 1999 Edition, at 2-1.4.1 requires swinging doors to be equipped with self closing devices which will cause the door to close and latch each time it is opened. This deficient practice could affect eight</p>	K 0020	<p>The Creation and submission of the Plan of Correction does not constitute and admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation.1. The self-closing device on the Vent Hall Stairwell door on the third floor has been repaired.2. All residents have the potential to be affected3. The Maintenance Director will monitor daily for one month and weekly thereafter.4. A maintenance log will be used to document the inspection. All results will be submitted to the monthly QA Committee.5. Date of Compliance: November 7, 2015</p>	11/07/2015

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K 0025 SS=E Bldg. 01	<p>residents, staff and visitors in the vicinity of the Vent Hall stairwell door on the third floor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, the Vent Hall stairwell door on the third floor had a 90 minute fire resistance rating and was provided with a self closing device but the door hit the frame on the handle side of the door and prevented the latching mechanism from protruding into the door frame when the door was attempted to self close five separate times. Based on interview at the time of observation, the Maintenance Director acknowledged the Vent Hall stairwell door on the third floor failed to latch into the door frame to provide the vertical opening with a fire resistance rating of at least two hours.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are</p>			

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	<p>protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 3 of 4 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 24 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, the following was noted:</p> <p>a. a two inch in diameter hole in the ceiling of the first floor Soiled Laundry Room behind the natural gas fired dryers which exposed the deck of the ceiling above.</p> <p>b. a three inch by ten inch hole in the ceiling of the first floor housekeeping supply room across the hall from the staff restroom in the service hall which exposed the deck of the ceiling above.</p> <p>c. a two inch in diameter hole in the ceiling of the second floor housekeeping closet by the nurse's station which exposed the deck of the ceiling above.</p>	K 0025	<p>The Creation and submission of the Plan of Correction does not constitute and admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation.1. a. The 2 inch in diameter hole in the ceiling of the soiled utility room has been repaired. b. The three inch by ten inch hole in the ceiling on the first floor housekeeping supply room has been repaired. c. The two inch in diameter hole in the ceiling on the second floor housekeeping closet has been repaired.2. All resident have the potential to be affected.3. The Maintenance Director will inspect, monitor and follow guidelines for "Penetration of Smoke Barriers" weekly x one and monthly thereafter. 4. A maintenance log will be used to document the inspection. All results will be submitted monthly to the QA Committee.5. Date of Compliance: November 7, 2015</p>	11/07/2015

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K 0029 SS=D Bldg. 01	<p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned holes in ceiling smoke barriers failed to maintain at least a one half hour fire resistance rating for the ceiling smoke barrier.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 hazardous areas such as central/bulk laundries larger than 100 square feet in size were separated from other areas by smoke resistant partitions and doors. This deficient practice could affect five staff and visitors in the service hall in the vicinity of the Soiled Laundry Room.</p>	K 0029	The Creation and submission of the Plan of Correction does not constitute and admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation.1. a. The two inch in diameter hole in the ceiling in the soiled utility room has been repaired. b. The wedge placed in between the corridor door and the	11/07/2015

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	<p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, the following was noted:</p> <p>a. a two inch in diameter hole was noted in the ceiling of the Soiled Laundry Room behind the natural gas fired dryers which exposed the deck of the ceiling above.</p> <p>b. a wedge was placed on the floor in between the corridor door and the door frame of the Soiled Laundry Room which propped the door open and created a two inch gap between the door and the door frame which was not smoke resistant.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the hole in the ceiling behind the dryers and the corridor door gap caused by the use a wedge on the floor did not separate this hazardous area from other spaces by smoke resistant partitions and doors.</p> <p>3.1-19(b)</p>		<p>soiled utility room has been removed.2. All staff have the potential to be affected.3. The Maintenance Director will inspect and monitor for smoke barrier protection weekly for one month and monthly thereafter.4. A maintenance log will be used to document the inspection. All results will be submitted to the monthly QA Committee.5. Date of Compliance: November 7, 2015</p>	

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K 0033 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>Based on observation and interview, the facility failed to enclose 1 of 2 stairways with construction having a fire resistance rating of at least two hours. LSC 8.2.5.2 requires openings shall be protected as appropriate for the fire resistance rating of the barrier. LSC 7.1.3.2.1(b) requires a two hour rating in existing buildings of four stories or more. 7.1.3.2.1(c) requires openings in separations shall be protected by fire door assemblies. NFPA 80, the Standard for Fire Doors and Fire Windows, 1999 Edition, at 2-1.4.1 requires swinging doors to be equipped with self closing devices which will cause the door to close and latch each time it is opened. This deficient practice could affect eight residents, staff and visitors in the vicinity of the Vent Hall stairwell door on the third floor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on</p>	K 0033	<p>The Creation and submission of the Plan of Correction does not constitute and admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation.1. The latching mechanism on the Vent Hall Stairwell Door on the third floor has been repaired.2. All residents and staff have the potential to be affected.3. The Director of Maintenance will inspect and monitor for latching daily for four weeks and weekly thereafter.4. A maintenance log will be used to document the inspection. All results will be submitted monthly to the QA Committee.5. Date of Compliance: November 7, 2015</p>	11/07/2015	

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K 0034 SS=E Bldg. 01	<p>10/08/15, the Vent Hall stairwell door on the third floor had a 90 minute fire resistance rating and was provided with a self closing device but the door hit the frame on the handle side of the door and prevented the latching mechanism from protruding into the door frame when the door was attempted to self close five separate times. Based on interview at the time of observation, the Maintenance Director acknowledged the Vent Hall stairwell door on the third floor failed to latch into the door frame to provide the stairway with a fire resistance rating of at least two hours.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 Based on observation and interview, the facility failed to ensure items stored in 1 of 2 interior fire escape stairways would not interfere with egress. LSC 7.2.2.5.3 requires usable space within an exit enclosure, including under stairs, or any open space within the enclosure shall not be used for any other purpose which</p>	K 0034	The Creation and submission of the Plan of Correction does not constitute and admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation.1. The buffer machine, housekeeping cart, mop bucket and bicycle have all been removed.2. All residents and	11/07/2015

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K 0038 SS=E Bldg. 01	<p>could interfere with egress. This deficient practice could affect 50 residents, visitors and staff using the north exit stairwell on the first floor for evacuation.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, the north stairwell on the first floor which was marked as a facility exit for the upper three floors of the facility was used to store a buffer machine which was plugged into an electrical outlet for charging, one housekeeping cart, two mop buckets and a bicycle. Based on interview at the time of observation, the Maintenance Director acknowledged the north stairwell on the first floor was used for storage of the aforementioned items which could interfere with egress.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1. Based on observation and interview, the facility failed to ensure the means of</p>	K 0038	<p>staff have the potential to be affected.3. The Maintenance Director will monitor daily to ensure items are not stored in the interior fire escape stairways that would interfere with egress.4. A maintenance log will be used to document the inspection. All results will be submitted monthly to the QA Committee.5. Date of Compliance: November 7, 2015</p> <p>The Creation and submission of the Plan of Correction does not</p>	11/07/2015	

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	<p>egress through 1 of 13 exits 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 states 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 could affect 50 residents, staff and visitors using the north stairwell exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, the north stairwell exit door to the outside of the facility was marked as a facility exit, the exit door was magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of observation, the Maintenance Director stated not all residents have a clinical diagnosis to be in a secure</p>		<p>constitute and admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation.1. a. Code on the North Stairwell Exit door has been posted. b. The keypad has been relocated to meet the requirements/guidelines. c. A handrail has been installed by the exit discharge ramp outside the Main Dining Room on the first floor.2. All residents and staff have the potential to be affected.3. The Maintenance Director will monitor and inspect the posting of the keypad code and maintain any maintenance that is required for the handrails and keypads in the facility.4. A maintenance log will be used to document the inspection. All result will be submitted monthly to the QA Committee.5. Date of Compliance: November 7, 2015</p>	

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	<p>building, the north stairwell exit to the outside of the facility can be used by residents evacuating the upper floors of the facility and acknowledged the four digit code was not posted at the north stairwell exit. Based on exit interview at 4:00 p.m., the Administrator confirmed not all residents have a clinical diagnosis to be in a secure building. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.</p> <p>3.1-19(b)</p> <p>2. Based on observations and interview, the facility failed to ensure 1 of 15 exit doors were provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. LSC 7.2.1.5.4 requires a latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 inches and not more than 48 inches above the finished floor. This deficient practice could affect 50 residents, staff and visitors using the north stairwell exit on the first floor.</p>			

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, the north stairwell exit to door to the outside of the facility was marked as a facility exit, the exit door was magnetically locked and could be opened by entering a four digit code into a keypad but the keypad was installed on top of the door frame 78 inches above the finished floor. Based on interview at the time of observation, the keypad releasing mechanism for the aforementioned facility exit door was installed above the door frame greater than 48 above the finished floor.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 15 exit accesses was provided with a handrail. LSC 7.2.2.4.2 states ramps shall have handrails on both sides. The required egress width shall be provided along the natural path. Exception No 3: Existing stairs, existing ramps, stairs within dwelling units and within guest rooms, and ramps within dwelling units and guest rooms shall be permitted to have a handrail on one side only. This deficient</p>			
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K 0048 SS=C Bldg. 01	<p>practice could affect 20 residents, staff and visitors if needing to exit the facility from the Main Dining Room on the first floor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, the exit discharge ramp outside the Main Dining Room on the first floor measured a one foot rise over the ten foot length of the ramp and was not provided with a handrail. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned ramp had a slope of 1 in 10 and was not provided with a handrail.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to document a complete written health care occupancy fire safety plan for 2 of 2 plans which incorporated all items listed in NFPA 101, Section</p>	K 0048	The Creation and submission of the Plan of Correction does not constitute and admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or	11/07/2015			

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	<p>19.7.2.2.</p> <p>(1) Use of alarms</p> <p>(2) Transmission of alarm to the fire department</p> <p>(3) Response to alarms</p> <p>(4) Isolation of fire</p> <p>(5) Evacuation of immediate area</p> <p>(6) Evacuation of smoke compartment</p> <p>(7) Preparation of floors and building for evacuation</p> <p>(8) Extinguishment of fire</p> <p>This deficient practice affects all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of "Disaster Action Plan" and "Disaster Preparedness Plan" documentation with the Maintenance Director during record review from 9:15 a.m. to 12:00 p.m. on 10/08/15, the written health care occupancy fire safety plans for the facility did not identify fire doors in the facility for the evacuation of smoke compartments. Section C "Evacuation Procedures" of the Disaster Action Plan stated "residents, staff and visitors in the wing where the disaster is located must be immediately moved beyond the nearest smoke/fire barrier doors." Additionally stated in the plan was as "a second option, the decision must be made as to the feasibility of</p>		<p>regulation.1. The fire doors have been identified and added to the Safety Plans of the Facility for the evacuation plan.2. All residents and staff have the potential to be affected.3. The Maintenance Director will update and maintain the evacuation plan for compliance.4. A maintenance log will be used to document the inspection. All results will be submitted monthly to the QA Committee.5. Date of Compliance: November 7, 2015</p>	

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K 0052 SS=F Bldg. 01	<p>evacuating residents horizontally into another area on the nursing unit behind fire doors (see diagram for evacuation procedure in Section A)." Section E of the Disaster Preparedness Plan stated to "keep all smoke/fire doors closed" and "continue removing in sequence all people in the area until all are past the fire compartment doors. Do not go back through fire doors." Based on interview at the time of record review, the Maintenance Director stated the facility has two written fire safety plans and acknowledge neither plan identified the location of smoke/fire doors within the facility for evacuation purposes.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>1. Based on record review and interview, the facility failed to document annual testing of the facility fire alarm system.</p>	K 0052	The Creation and submission of the Plan of Correction does not constitute and admission by this provider of any conclusion set	11/07/2015

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	<p>NFPA 72, 7-3.2 refers to fire alarm component testing frequencies in Table 7-3.2 which requires an annual fire alarm system test. Section 7-5.2 requires a permanent record of all inspections, testing and maintenance shall be provided that includes information requested in Figure 7-5.2.2. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of Vanguard Alarm Services "Inspection and Testing Certificate" documentation dated 02/16/15 and 06/30/15 with the Maintenance Director during record review from 9:15 a.m. to 12:00 p.m. on 10/08/15, documentation of annual functional testing of all fire alarm system initiating devices was not available for review. The aforementioned documentation stated 28 of 184 initiating devices were functional tested on 02/16/15 and 89 of 185 initiating devices were functional tested on 06/30/15.</p> <p>Based on interview at the time of record review, the Maintenance Director stated Vanguard had confirmed by telephone interview at 11:30 a.m. all initiating devices had not been functional tested within the most recent twelve month period, documentation of additional fire</p>		<p>forth in the statement of deficiencies, or of any violation or regulation.1. a. The annual functional of all fire alarm system initiating devices has been completed. b. The fire alarm system breaker in the panel/mechanical electrical room has been secured.2. All residents and staff have the potential to be affected.3. The Maintenance Director will monitor for timely inspection of the alarm system initiating devices and monitor for the alarm system breaker to be secure.4. A maintenance log will be used to document the inspection. All results will be submitted monthly to the QA Committee.5. Date of Compliance: November 7, 2015</p>	

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	<p>alarm system initiating devices testing within the most recent twelve month period was not available for review and acknowledged documentation of annual functional testing of all fire alarm system initiating devices within the most recent twelve month period was not available for review.</p> <p>3-1.19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a</p>			

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K 0062 SS=E Bldg. 01	<p>locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, the fire alarm system breaker in the first floor Alarm Panel/Mechanical Electrical Room was not in a locked or sealed cabinet. Based on interview at the time of observation, the Maintenance Director acknowledged the fire alarm system breaker was not in a locked or sealed cabinet.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to replace 1 of over 100 sprinklers which had become corroded, had paint, lint or other foreign materials</p>	K 0062	The Creation and submission of the Plan of Correction does not constitute and admission by this provider of any conclusion set forth in the statement of	11/07/2015

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	<p>on them. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 26 residents, staff and visitors in the vicinity of Room 204.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, the pendant sprinkler installed in the closet for Room 204 was wrapped with masking tape to prevent paint from being applied to the sprinkler. Based on interview at the time of observation, the Maintenance Director stated Room 204 had been recently painted and acknowledged the aforementioned sprinkler location had foreign materials attached to it.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure a clearance of at least 18 inches was maintained below</p>		<p>deficiencies, or of any violation or regulation.1. a. The sprinkler installed in the closet in room 204 which was wrapped with masking tape has been removed. All sprinklers heads in the facility has been inspected to meet compliance. b. The shower curtain in the Spa was replaced with a 18 inch mesh shower curtain. 2. All residents and staff have the potential to be affected.3. The Maintenance Director will monitor all sprinkler devices and monitor any obstruction less than or equal to 18 inches below the sprinkler deflector that would prevent the spray pattern from fully developing.4. A maintenance log will be used to document the inspection. All results will be submitted monthly to the QA Committee.5. Date of Compliance: November 7, 2015</p>	

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	<p>the level of the sprinkler deflectors in 1 of 4 shower rooms in the facility. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, 1999 edition, at 5-5.5.1 says a continuous or noncontiguous obstruction less than or equal to 18 inches below the sprinkler deflector prevents the spray pattern from fully developing. This deficient practice could affect 20 residents, staff and residents in the vicinity of the Spa on the fourth floor.</p> <p>Finding includes:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, one of one shower curtains was affixed to a horizontal rod three inches below the ceiling in the Spa on the fourth floor. The curtain had no mesh openings at the top of the curtain to provide a minimum 18 inch clearance below the one sprinkler head deflector in the room. Based on interview at the time of observation, the Maintenance Director acknowledged at least 18 inches clearance was not provided for the sprinkler installed in the aforementioned shower room due to the use of the shower curtain hung from the ceiling with no openings provided in the curtain.</p>			

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K 0069 SS=D Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen range hood fire extinguishing equipment was maintained in accordance with NFPA 96. LSC 9.2.3 refers to NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, Section 7-4.1 states upon activation of any fire-extinguishing system for a cooking operation, all sources of fuel and electric power that produce heat to all equipment requiring protection by that system shall automatically shut off. This deficient practice could affect three staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on review of Vanguard Alarm Services "Periodic Range Hood Suppression System Testing and</p>	K 0069	The Creation and submission of the Plan of Correction does not constitute and admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation.1. A shunt was installed to kill electrical appliances under the hood upon activation of the range hood suppression system.2. All staff in the area have the potential to be affected.3. The Maintenance Director will monitor and maintain annual log of inspections and follow up for compliance.4. A maintenance log will be used to document the inspection. All results will be submitted bi-annually to the QA Committee.5. Date of Compliance: November 7, 2015	11/07/2015			

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	<p>Inspection Report" documentation dated 01/23/15 and 06/30/15 with the Maintenance Director during record review from 9:15 a.m. to 12:00 p.m. on 10/08/15, the two most recent semiannual range hood fire extinguishing equipment inspections "Comments" sections stated "electrical appliances didn't shut down when system was activated" and "No/Fail" was listed as the response to item No. 15 "Check operation of micro switch." Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, all appliances protected by the kitchen range hood suppression system were electrically powered and used no natural gas or other fuel(s). Based on interview at the time of record review, the Maintenance Director stated documentation of corrections to the range hood fire extinguishing equipment on or after 06/30/15 was not available for review and acknowledged corrections to the range hood fire extinguishing equipment micro switch and electric shutoff had not been performed.</p> <p>3.1-19(b)</p>			

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K 0071 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes:</p> <p>(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5.</p> <p>(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7.</p> <p>(3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4.</p> <p>(4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 laundry chutes, a vertical opening, was provided with automatic extinguishing protection in accordance with LSC 9.7. LSC 9.7 states each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler</p>	K 0071	The Creation and submission of the Plan of Correction does not constitute and admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation.1. The Facility rendered the laundry chute doors in-operable and the chutes out of service.2. All residents and staff have the potential to be	11/07/2015

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	<p>Systems. NFPA 13, section 5-13.5 states building service chutes (e.g. linen) shall be protected internally by automatic sprinklers. A sprinkler shall be provided above the top service opening of the chute, above the lowest service opening, and above service openings at alternate levels in buildings over two stories in height. The room or area into which the chute discharges shall also be protected by automatic sprinklers. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, the laundry chute is not provided with automatic sprinkler protection at any service opening level in the building. Based on interview at the time of observation, the Maintenance Director acknowledged the laundry chute was not provided with automatic sprinkler protection at any service opening level in the building.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 laundry chutes were provided with fire door</p>		<p>affected.3. The Maintenance Director will monitor that the chutes are secure at all times.4. A maintenance log will be used to document the inspection. All results will be submitted to the QA Committee.5. Date of Compliance: November 7, 2015</p>	

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K 0076 SS=E Bldg. 01	<p>assemblies having a fire protection rating of one hour. LSC 8.4.1.3 states doors in barriers required to have a fire resistance rating shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect two staff and visitors in the Soiled Laundry Room on the first floor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, the Soiled Laundry Room laundry chute door failed to self close and latch into the door frame when the door was attempted to self close and latch five separate times. Based on interview at the time of observation, the Maintenance Director acknowledged the Soiled Laundry Room laundry chute door failed to self close and latch into the door frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with</p>			

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	<p>NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3,000 cubic feet was enclosed with separation of 1 hour fire resistive construction. LSC 8.2.3.2.1 requires doors in fire barriers shall be of an approved type with the appropriate fire protection rating. Further, 8.2.3.2.1(b) requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect 8 residents, staff and visitors in the vicinity of the third floor oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, ten liquid oxygen containers were stored in the third floor oxygen storage and transfilling room. The corridor entry door was equipped with a self closing device but the door failed to self close and latch into the frame</p>	K 0076	<p>The Creation and submission of the Plan of Correction does not constitute and admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation.1. The corridor door of the Oxygen room on the third floor has been repaired to self-close and latch into the frame and the "L" shaped crack has been repaired to provide the one hour fire protection.2. All residents and staff have the potential to be affected.3. The Maintenance Director will monitor all self-closing latch doors and repair all cracks to maintain fire resistive compliance.4. A maintenance log will be used to document the inspection. All results will be submitted monthly to the QA Committee.5. Date of Compliance: November 7, 2015</p>	11/07/2015

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K 0143 SS=E Bldg. 01	<p>because the door hit the frame on the handle side when it was attempted to self close five separate times. An 'L' shaped crack 15 inches long by one inch wide was noted in the ceiling which did not provide the room with separation of one hour fire resistive construction. In addition, a three inch by five inch hole was noted in the south wall of the room two feet above the floor. Based on interview at the time of the observations, the Maintenance Director acknowledged the corridor entry door failed to self close and the aforementioned openings did not enclose the oxygen storage and transfilling room with one hour fire resistive construction.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(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;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p>			

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	<p>(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.</p> <p>8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure the 1 of 1 liquid oxygen transfilling areas was enclosed with separation of 1 hour fire resistive construction. LSC 8.2.3.2.1 requires doors in fire barriers shall be of an approved type with the appropriate fire protection rating. Further, 8.2.3.2.1(b) requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect 8 residents, staff and visitors in the vicinity of the third floor oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, ten liquid oxygen containers were stored in the third floor oxygen storage and transfilling room. The corridor entry door was equipped with a self closing device but the door failed to self close and latch into the frame because the door hit the frame on the handle side when it was attempted to self</p>	K 0143	<p>The Creation and submission of the Plan of Correction does not constitute and admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation.1. The corridor door of the Oxygen room on the third floor has been repaired to self-close and latch into the frame and the "L" shaped crack has been repaired to provide the one hour fire protection.2. All residents and staff have the potential to be affected.3. The Maintenance Director will monitor all self-closing latch doors and repair all cracks to maintain fire resistive compliance.4. A maintenance log will be used to document the inspection. All results will be submitted monthly to the QA Committee.5. Date of Compliance: November 7, 2015</p>	11/07/2015

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K 0144 SS=F Bldg. 01	<p>close five separate times. An 'L' shaped crack 15 inches long by one inch wide was noted in the ceiling which did not provide the room with separation of one hour fire resistive construction. In addition, a three inch by five inch hole was noted in the south exterior wall of the room two feet above the floor. Based on interview at the time of the observations, the Maintenance Director acknowledged the corridor entry door failed to self close and the aforementioned openings did not enclose the oxygen storage and transfilling room with one hour fire resistive construction.</p> <p>3.1-19(b)</p> <p>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.</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 10 of 12 months 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</p>	K 0144	The Creation and submission of the Plan of Correction does not constitute and admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation.1. a. Van Guard has completed the Annual Load Bank Test due to our inability to load test the generator at 30% or greater than its graded capacity.	11/07/2015

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	<p>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, Standard for Emergency and Standby Power Systems. 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:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>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 maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator - Weekly Exercise/Monthly Load Test Log" documentation with the</p>		<p>b. The battery powered emergency light at the emergency generator location has been repaired and is functional. c. The Emergency Power Supply System Room has been cleared of all stored supplies. 2. All residents and staff have the potential to be affected.3. The Maintenance Director will maintain a schedule and monitor the completion of the Emergency Generator Test and the maintenance of the emergency task lighting as well as making sure that the EPSS room is not used for any storage of supplies.4. A maintenance log will be used to document the inspection. All results will be submitted monthly to the QA Committee.5. Date of Compliance: November 7, 2015</p>	

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	<p>Maintenance Director during record review from 9:15 a.m. to 12:00 p.m. on 10/08/15, documentation of monthly load testing for the ten month period of 12/26/14 through 09/25/15 did not record the monthly load test as 30% or greater of the Emergency Power Supply (EPS) nameplate rating. In addition, each of the aforementioned monthly load tests did not document the test was under operating temperature conditions or at loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Based on interview at the time of record review, the Maintenance Director stated a new 300 kW diesel generator was installed in December 2014 and acknowledged monthly load testing documentation for the aforementioned ten month period did not state the load test achieved 30% or greater of the EPS nameplate rating, was under operating temperature conditions or at loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide adequate emergency task lighting in and around the generator set in accordance with NFPA</p>			

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	<p>101, 2000 Edition, Life Safety Code. Section 19.2.9.1 states emergency lighting shall be provided in accordance with Section 7.9. LSC Section 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires the EPS (Emergency Power Supply) equipment location shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, the battery powered emergency light at the emergency generator location failed to operate when its respective test button was depressed five times. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned battery operated emergency light failed to illuminate when its respective test button was depressed.</p> <p>3.1-19(b)</p>			

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	<p>3. Based on observation and interview, the facility failed to ensure Level 1 Emergency Power Supply System (EPSS) rooms which includes transfer switch rooms was not used as a storage room. NFPA 99, Section 3-4.1.1.6(a) states rooms for such equipment shall not be shared with other equipment or electrical service equipment that is not a part of the essential electrical system in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, Section 5.2.1 states no other equipment may be permitted in an EPSS room except those that serve this space. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, sheets and linen were stored in plastic bags up against the Level 1 EPSS transfer switch and the Generator Disconnect electrical panel in the former emergency generator room on the first floor. In addition, mop buckets, housekeeping supplies and boxes were also being stored in the transfer switch room. Based on interview at the time of observation, the Maintenance Director stated a new emergency generator was</p>			

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K 0147 SS=F Bldg. 01	<p>installed outside the facility, the former emergency generator room was being used as a storage room and acknowledged the emergency generator transfer switch room was being used as a storage room.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of 2 main electrical rooms. NFPA 70, Article 110-26(a) states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of Article 110-26(a)(1), (2) and (3). Distances shall be measured from the live parts if such</p>	K 0147	The Creation and submission of the Plan of Correction does not constitute and admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation.1. a. All linens stored against the emergency generator transfer switch has been removed. b. The power strips in the clean laundry room and the Director of Nursing office has been removed.2. All residents and staff have the potential to be affected.3. The Maintenance Director will monitor to ensure the	11/07/2015

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	<p>parts are exposed or from the enclosure front or opening if such are enclosed. Article 110-26(b) states the working space required by this section shall not be used for storage. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, sheets and linen were stored in plastic bags up against the emergency generator transfer switch and the Generator Disconnect electrical panel in the former emergency generator room on the first floor. Based on interview at the time of observation, the Maintenance Director stated a new emergency generator was installed outside the facility, the former emergency generator room was being used as a storage room and acknowledged sheets and linen were stored in plastic bags up against the emergency generator transfer switch and the Generator Disconnect electrical panel in the former emergency generator room on the first floor.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview,</p>		<p>access and working space is maintained in enclosures housing electrical apparatus and also monitor the usage of extension cords.4. A maintenance log will be used to document the inspection. All results will be submitted monthly to the QA Committee.5. Date of Compliance: November 7, 2015</p>				

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	<p>the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, 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 8 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/08/15, a microwave oven was plugged into a power strip in the Clean Laundry Room on the first floor and in the Assistant Director of Nursing Office on the third floor. Based on interview at the time of the observations, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned two locations.</p> <p>3.1-19(b)</p>			