

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155223	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/02/2014
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NAME OF PROVIDER OR SUPPLIER  WATERS OF COVINGTON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932
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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 Date: 04/02/14</p> <p>Facility Number: 000128 Provider Number: 155223 AIM Number: 100289650</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Waters of Covington was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and in spaces open to the corridors. Resident sleeping rooms are equipped with battery powered</p>	K010000	The creation and submission of this plan of correction does not constitute any admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Provider desires that the 2567 plan of correction be considered the letter of credible allegation of compliance on or after May 2, 2014. Fay Pruitt, HFA	
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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>smoke detectors. The facility has a capacity of 127 and had a census of 97 at the time of this survey.</p> <p>All areas with resident access were sprinklered. All areas providing facility services were sprinklered except a detached smoke hut and storage shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/08/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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 1¼ 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.</p> <p>1. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 2 of 11 smoke compartments could automatically latch into their door frames. This deficient practice affects staff, visitors and 30 or more residents in the dining room and fountain Wing smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/02/14 between 11:30 a.m. and 1:30 a.m.:</p> <p>a. Doors to the storage room across from the business office and to the dietary manager's office were equipped with dead bolt latches which had to be turned with a</p>	K010018	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1a) Door knob with positive latch installed on business office storage room door and dietary manager's office door. b) Latching hardware on therapy room doors were unlocked and heavy duty slide bolt latch removed. 2a) Kick down door stop removed from break room door. b) Can removed from dietary storage rom door. c) Fall mat removed from door way to resident room 21 and 26. How other resident having the potential to be affected by the same deficirnt practice will be identified and what corrective action(s) will be taken: The maintenance director and HFA shall examine all areas of the building to ensure doors have proper door knobs</p>	05/02/2014
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	<p>key or the interior latch to secure the doors into their frames. The maintenance director said at the time of observations, the deadbolts were installed due to recent incidents of vandalism and theft.</p> <p>b. Two double door sets to the Fountain physical therapy room did not latch. The maintenance director said the latching hardware was locked in the open position to allow passage through the doors without having to push on the bars which released the latches. In addition both sets of doors were equipped with heavy duty slide bolt latches.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure corridor doors in 2 of 11 smoke compartments did not have impediments to closing. This deficient practice affects staff, visitors and 30 or more residents in the main dining room, ICF and skilled smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/02/14 between 11:30 a.m. and 1:30 p.m., doors to the following areas were prevented from closing by:</p> <p>a. Kick down door stops to the employee</p>		<p>(positive latch) and doors are not prevented to close. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director shall conduct monthly rounds to ensure doors are not prevented from closing properly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: The maintenance director shall report to Quality Assurance Committee. The Quality Assurance Committee shall provide suggestions if necessary. And by what date the systemic changes will be completed: May 2, 2014</p>				

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	<p>break room and resident room 51;</p> <p>b. Canned goods stacked in front of the wide open door to the dietary storage room;</p> <p>c. Mattresses in resident rooms 21 and 26.</p> <p>The maintenance director acknowledged at the time of observations, the doors were prevented from closing.</p> <p>3.1-19(b)</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 12 doors to hazardous areas 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 10 or more staff in the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/02/14 between 11:30 a.m. and 1:30 p.m., the self closing doors to the unoccupied service corridor mechanical/boiler room was prevented from closing by a rubber wedge which held the door wide open and the self closing door to the maintenance shop/office was prevented</p>	K010021	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Wedge removed from the self closing doors to the unoccupied service corridor mechanical/boiler room. Cardboard carton removed from in front of maintenance shop/office door. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The maintenance director and HFA shall examine all areas of the building to ensure doors are not prevented from closing properly. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director shall conduct monthly rounds to ensure doors are not</p>	05/02/2014			

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	<p>from closing by a cardboard carton placed in front of the door to hold it open. The maintenance director acknowledged at the time of observations, the doors would not automatically close.</p> <p>3.1-19</p>		<p>prevented from closing properly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The maintenance director shall report to Quality Assurance committee. The Quality Assurance Committee shall provide suggestions if necessary. And by what date the systemic changes will be completed: May 2, 2014</p>	

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully 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 openings in ceiling smoke partitions were sealed to limit the transfer of smoke in 1 of 13 smoke compartments. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke . This deficient practice could affect visitors, staff and 20 or more residents in the adjacent dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/02/14 between 10:30 a.m. and 1:30 p.m.:</p> <p>a. Two conduit penetrations of the kitchen ceiling were unsealed leaving one half and three fourths inch gaps into the attic above;</p> <p>b. Two eight inch ducts in the laundry penetrated the ceiling. A two inch circumference around the ducts was</p>	K010025	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A)B) Penetrations of the kitchen and laundry room ceiling repaired with fire-rated caulking. C) Repair to laundry room ceiling completed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The maintenance director and HFA shall examine all areas of the building to ensure all penetrations/gaps are sealed/repared properly. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director shall conduct monthly rounds to ensure areas are sealed properly to prevent smoke penetration. How the corrective action(s) will be monitored to ensure the deficient</p>	05/02/2014			

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	<p>unsealed.</p> <p>c. Drywall repairs to damage to the laundry ceiling were incomplete. Gaps of one by four inches, and one by twelve inches remained where the drywall was pieced together.</p> <p>The maintenance director acknowledged at the time of observations, the openings should have been sealed.</p> <p>3.1-19(b)</p>		<p>practice will not recur, i.e., what quality assurance program will be put into place: The maintenance director shall report to Quality Assurance Committee. The Quality Assurance Committee shall provide suggestions if necessary. And by what date the systemic changes will be completed: May 2, 2014.</p>	

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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>1. Based on observation and interview, the facility failed to ensure 2 of 12 doors to hazardous areas, such as a storage rooms larger than 50 square feet, and an elevator equipment room closed automatically or upon activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch into the door frame when closed to keep the door tightly closed. This deficient practice affects visitors and 40 residents in the South Hall and 10 or more staff in the South Hall and Service Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/02/14 between at 10:30 a.m. and 1:30 p.m.:</p> <p>a. The doors to the self closing south service window between the main dining room and kitchen were closed. One door</p>	K010029	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1)A) doors to the self closing south service window between the main dining room and kitchen repaired. B) self closing door to the laundry room was repaired. C) self closing door between the kitchen and service corridor repaired. 2) self closing device applied door to storage room (52). How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The maintenance director and HFA shall examine all doors in building to ensure all doors are operating properly. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director shall conduct monthly rounds to ensure all doors</p>	05/02/2014			

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	<p>gapped two inches. Upon closer inspection by the maintenance director, he said the door had hit the latch and failed to close into the door frame.</p> <p>b. The self closing door to the laundry was closed but not latched. When tested with the maintenance director, the door latch hit the door frame but failed to close into the door frame;</p> <p>c. The self closing door between the kitchen and service corridor gapped two inches. Upon closer inspection by the maintenance director at the time of observation, the door was loose in the frame and could not self close. He called an assistant to make repairs.</p> <p>d. The south shower room was used for the collection of 50 gallon capacity soiled linen and trash barrels which were two thirds full. The self closing door failed to latch into the door frame when tested twice by the maintenance director. The maintenance director said at the time of observation, the latch had "gone bad."</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide automatic closers for doors providing access to 1 of 10 hazardous areas such as a combustibile materials storage room larger than 50 square feet. Sprinklered hazardous areas are required to be equipped with self</p>		<p>operate properly. How the corrective action(s) will be monoitored to ensure the deficient practice will not recur, i.e., what quality assuance program will be put into place: The maintenance director shall report to Quality Assuance Committee. The Quality Assurance committee shall provide suggestions if necessay. And, by what date the systemic changes will be completed: May 2, 2014</p>	

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	<p>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 skilled smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/02/14 at 12:35 p.m., former resident room 52 was being used as a storage room for mattresses, cardboard cartons and miscellaneous equipment. The door separating the 16 by 12 foot storage room from the exit corridor had no self closing device. The maintenance director said at the time of observation, he didn't know the door was required to self close.</p> <p>3.1-19(b)</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>1. Based on observation and interview, the facility failed to ensure 1 of 12 exits were unobstructed. LSC 7.2.1.4 requires a means of egress shall be continuously maintained free of all obstructions or impediments to full and instant use in case of fire or other emergency. LSC 7.2.1.4.5 requires the forces to to fully open a door in a means of egress shall not exceed 30 lbf to set the the door in motion and 15 lbf to open the door. This deficient practice affects visitors, staff, and 20 or more residents on the Fountain wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/02/14 at 12:00 p.m., a set of double doors provided an emergency exit to the outside from the Fountain physical therapy room. The doors were tested and were "stuck." They could not be opened until the full body weight of the maintenance director was pushed against the doors. The maintenance director agreed at the time of observation, the doors required more than the maximum force permitted to open the doors. He said he would have to</p>	K010038	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Double doors to outside from therapy room repaired. 2 "Push until alarm sounds door can be opened in 15 seconds" placed at exit doors to Hope Springs hall. 3) Service corridor exit clutter removed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The maintenance director and HFA shall examine all doors and halls to ensure doors operate properly and halls are clear of clutter. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director shall conduct monthly checks to ensure that all doors operate properly and that all halls are clear of clutter. How the corrective action(s) will be monitored to ensure the deficient practice will recur, i.e., what quality assurance program will be put into place: The maintenance director shall report to Quality Assurance committee. The quality Assurance committee shall provide suggestions if</p>	05/02/2014
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	<p>"work on the doors" to get them to open properly.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 13 exit doors met all the conditions of LSC, Section 7.2.6.1. Health care occupancies permit delayed egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS." This deficient practice could affect visitors, staff and 20 or more residents in the Hope Springs smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/02/14 at 12:45 p.m., two exit doors from the Hope Springs wing were equipped with delayed egress locks which released after fifteen seconds but lacked the proper signage. The maintenance director acknowledged at the time of observation, the signs were</p>		necessary. And by what date the systemic changes will be completed: May 2, 2014				

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	<p>missing.</p> <p>3.1-15(b)</p> <p>3. Based on observation and interview, the facility failed to ensure egress for 1 of 12 exits was arranged to be accessible. LSC 19.2.1 requires compliance with LSC 7.1, Means of Egress. LSC 7.1.3.2.3 requires an exit enclosure shall not be used for any purpose with the potential to interfere with its use as an exit. LSC 7.1.10.1 "Means of egress shall be continuously free of all obstructions or impediments to full instant use in case of fire or other emergency use." This deficient practice affects visitors and 10 or more staff in the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/02/14 at 1:15 p.m., the egress path for the service corridor exit was cluttered with a Hoyer lift, suction machine, six cardboard cartons and a maintenance equipment cart which diminished the path of egress to three and one half feet in one area for a distance of four feet. The maintenance director said at the time of observation, some of the equipment had been left there for repair. He acknowledged the minimum four foot exit egress width had</p>			
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	not been maintained.  3.1-(19)			

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K010046 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>1. Based on record review and interview, the facility failed to provide complete documentation of 30 second periodic testing at 30 day intervals and annual testing for 1 1/2 hours of 1 of 1 battery powered emergency lighting fixtures. LSC 7.9.3 requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test shall be conducted for not less than 1 1/2 hours. Written records of visual inspections and tests shall be kept. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/02/14 at 11:55 a.m. the emergency lighting located at the emergency generator was tested. Both bulbs in the fixture failed to illuminate. The maintenance director acknowledged at the time of observation the emergency light was not working. Based on review of the monthly preventive maintenance records with the maintenance director on 04/02/14 at 1:30 p.m., a record of testing for the battery</p>	K010046	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Unit with the light bulbs on emergency generator replace. Checking of the emergency light has been added to maintenance weekly check list. 2) Emergency light fixture was replaced. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The maintenance director and contracted vendor shall examine emergency generator to ensure proper working condition. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director shall continue monthly rounds to ensure generator is operating properly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: The maintenane director shall report to Quality Assurance committee. The Quality Assurance committee shall provide suggestions of necessary. And by what date the systemic changes will be</p>	05/02/2014	

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	<p>powered emergency light fixture provided for the generator was not found. The maintenance director said at the time of record review, he checked the light regularly but never documented the test and no record of a 1 1/2 hour test was documented.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 battery powered emergency lighting fixtures would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice could affect all occupants if the generator task lighting were needed to maintain and repair the generator during a power outage.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/02/14 at 11:55 a.m., the battery powered emergency lighting provided for the emergency generator site was tested three times but failed to work. The maintenance director said at the time of observation, "I wrote a work order on it." He said he was the person to repair or replace the fixture and he thought ice fell from a gutter above the fixture and</p>		completed: May 2, 2014		

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	damaged it.  3.1-19 (b)			
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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>1. Based on observation and interview, the facility failed to ensure a supply of at least six spare sprinkler heads was kept on the premises in a cabinet for each type of sprinkler head installed in the building. NFPA 25, 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect visitors, staff, and 10 or more residents in the main dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/02/12 between 11:30 a.m. and 1:30 p.m., four different types of sprinkler heads were in use in the building. Only one sprinkler head for the sidewall sprinkler heads in use and one for another pendant head</p>	K010062	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Two spare sprinkler heads for each type of sprinkler heads in buidling ordered. 2)A) Box in kitchen freezer moved. B) Storage boxes in fountain wing janitors supplies closet moved to ensure 18 inch clearance from sprinkler head. C) Storage boxes in fountain wing medicine room moved to ensure 18 inch clearance from sprinkler head. 3) All sprinkler heads cleaned or replaced if necessary. 4)A) Sprinkler head under entrance canopy replaced. B) Sprinkler in activities office storage closet and over break room sink replaced. C) Sprinkler head in the maintenance office, resident room 81 and in the main dining room replaced. D) Sprinkler head in laundry room replaced. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The maintenance director and sprinkler system contractor shall examine all sprinkler heads in building to ensure that two spare sprinkler heads per each type of</p>	05/02/2014			

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	<p>type were found in the spare sprinkler head cabinet. The maintenance director said at the time of discovery, all spare heads were located in the box. He acknowledged at the time of observation, there were not two spare heads for all types of sprinklers in the facility.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure sprinkler heads in 2 of 13 smoke compartments were free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice affects visitors, staff and 30 or more residents in the main dining room and Fountain hall smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/02/14 between 11:30 a.m. and 12:00 p.m.,</p> <p>a. a box in the kitchen freezer was located four inches from the only sprinkler head providing protection for</p>		<p>sprinkler heads is available within the building and that all sprinkler heads are clean. The maintenance director and HFA shall conduct rounds to ensure that all sprinklers heads have at least 18 inch clearance of boxes/storage. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director shall conduct monthly checks to ensure all sprinkler heads are clean and that all sprinkler heads have at least 18 inch clearance of boxes/storage. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The maintenance director shall report to Quality Assurance committee. The Quality Assurance committee shall provide suggestions if necessary. And, by what date the systemic changes will be completed: May 2, 2014</p>				

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	<p>the area;</p> <p>b. storage in the Fountain wing janitors supply closet was located eight inches from the sprinkler head;</p> <p>c. storage boxes in the Fountain medicine room were four inches from the sprinkler head.</p> <p>The maintenance director acknowledged at the time of observations, the sprinkler heads were less than the minimum distance allowed between a sprinkler head and obstruction.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure sprinkler heads in 2 of 13 smoke compartments were free of corrosion and foreign materials, such as grime. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 20 or more residents in the service corridor and entrance smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/02/14 between 11:30 a.m. and 1:30 p.m., three sprinkler heads in the laundry and one behind the commercial gas dryers were</p>			
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	<p>covered with a gray fuzzy grime. Eight sprinkler head protecting the entrance canopy were turning green, usually evidence of corrosion. The maintenance director agreed at the time of observations, the foreign materials could affect the function of the sprinkler heads.</p> <p>3.1-19(b)</p> <p>4. Based on observation and interview, the facility failed to ensure sprinkler heads were maintained under the entrance canopy and in 3 of 13 smoke compartments. This deficient practice could affect staff, visitors and 30 or more residents in the main dining room, maintenance, and Fountain wing smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the maintenance director on 04/02/14 between 11:30 a.m. and 1:30 p.m., sprinkler head escutcheons were missing, improperly installed, or displaced leaving a gaps of one half to two inches into the attic or interstitial spaces above:</p> <p>a. One sprinkler head escutcheon under the main entrance canopy was displaced;</p> <p>b. The escutcheon was missing from the activities office storage closet and over</p>						

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	<p>the employee break room sink;</p> <p>c. Escutcheons were loose in the maintenance office, resident room 81, and in the main dining room (one).</p> <p>d. Gaps around three sprinkler escutcheons in the laundry each exceeded one inch and one sprinkler head in the laundry was missing an escutcheon</p> <p>The maintenance director acknowledged at the time of observations, the sprinklers were not in good condition.</p> <p>3.1-19(b)</p>			
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K010064 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure a portable fire extinguisher in 1 of 13 smoke compartments was readily accessible. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.3 requires extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. This deficient practice affects staff, visitor, and 20 or more residents in the adjacent dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/02/14 at 12:15 p.m., a portable fire extinguisher located in the employee break room was located behind a large trash can. The maintenance director acknowledged at the time of observation, the trash can would have to be moved to get the fire extinguisher. The trash can remained in front of the fire extinguisher on 04/02/13 at 1:00 p.m.</p> <p>3.1-19(b)</p>	K010064	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Fire extinguisher relocated within breakroom. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The maintenance director and HFA shall examine all fire extinguishers to ensure that there is nothing blocking access. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director shall conduct monthly checks to ensure all fire extinguishers are easily accessible. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The maintenance director shall report to Quality Assurance committee. The Quality Assurance committee shall provide suggestions if necessary. And, what date the systemic changes will be completed: May 2, 2014</p>	05/02/2014			

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K010066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, interview, and record review; the facility failed to enforce the facility wide smoking policy and ensure 1 of 1 designated smoking areas was provided with a self closing metal container for ashtray waste disposal. This deficient practice affects any residents, staff and visitors in and around the service corridor and Fountain wing exits where staff and visitors were observed to come and go from the facility.</p> <p>Findings include:</p>	K010066	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A) North end of entrance is a designated smoking area. Self closing container purchased and in place. B) Self closing container by the employee smoking area has been replaced. C) Cigarette butts in mulch near fountain wing entrance removed. D) smoking policy updated to include employee and visitor smoking. How other residents having the potential to be affected by the same deficient practice will be</p>	05/02/2014			

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	<p>a. Based on observation with the maintenance director on 04/02/14 at 11:50 a.m., a full ashtray was observed under the entrance canopy to the facility. The area smelled of cigarettes and there was no self closing metal container observed for the disposal of the ash tray butts. The maintenance director said at the time of observation the area was not a designated smoking area.</p> <p>b. Based on observation with the maintenance director on 04/02/14 at 12:00 p.m., a designated smoking area outside the employee entrance from the service corridor was located under a three sided "smoke hut." A metal container with a self closing mechanism located eight feet away from the hut was identified by the maintenance director for the purpose of emptying ash trays. The can was completely full and did not self close when opened repeatedly.</p> <p>c. Based on observation with the maintenance director on 04/02/14 at 12:30 p.m., the exit discharge along the Fountain wing entrance was heavily mulched. Cigarette butts littered the mulched areas. The maintenance director acknowledged at the time of observation, there was a risk of fire if the disposal of cigarette butts onto mulched areas continued in dry conditions.</p> <p>d. A review of two documents provided</p>		<p>identified and what corrective action(s) will be taken: The maintenance director and HFA shall examine all designated smoking area to ensure that self closing container are in place and smoking area/mulch are clear of cigarette butts/etc.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director shall conduct monthly rounds to ensure all smoking area self closing containers are working properly and that smoking areas are clean. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The maintenance director shall report to quality assurance committee. The quality assurance committee shall provide suggestions if necessary. And, by what date the systemic changes will be completed: May 2, 2014</p>		

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	<p>as the facility smoking policy were reviewed with the maintenance director on 04/02/14 at 2:20 p.m. The documents addressed smoking only by residents in a designated area. Additionally the documents identified the facility as "smoke free." There was nothing to address repeated smoking by visitors and employees. One employee was observed smoking repeatedly under the entrance canopy during the tour between 11:30 a.m. and 1:30 p.m.</p> <p>3.1-19(b)</p>			
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K010070 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to provide evidence 1 of 1 space heaters was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice could affect visitors, staff and 20 or more residents in main dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/02/14 at 11:45 a.m., a portable space heater was located in the service corridor mechanical room where a service water heater, water softener and the riser for the automatic sprinkler system was located. The maintenance director said he used the space heater to keep a pipe in the room from freezing. The maintenance director said at the time of observation, he had no evidence the space heater element would not exceed the 212 F degree limit. The outside temperature was reported by the local radio station to be 51 degrees Fahrenheit. During record review on</p>	K010070	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Policy for space heater. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The maintenance director and HFA shall examine all areas of building to ensure portable space heaters are only being used per facility policy. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director shall conduct monthly rounds to ensure no portable space heaters are being used other than per facility policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The maintenance director shall report to quality assurance committee. The quality assurance committee shall provide suggestions if necessary. And, by what date the systemic changes will be completed:</p>	05/02/2014			

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	04/02/14 at 1:45 p.m., no policy was found for the use of the space heater. The maintenance director said at the time of record review, he had "never seen one."  3.1-19(b)		Compliance justified per policy May 2, 2014		

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K010074 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure loosely hanging fabrics in 1 of 13 smoke compartments were rendered flame resistant. LSC 19.7.5.1 requires draperies and other loosely hanging fabrics to be in accordance with 10.3.1. LSC 10.3.1 requires draperies, curtains, and other similar loosely hanging furnishings and decorations to have flame resistance as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice affects visitors, staff and 20 or more residents in the Fountain smoke compartment.</p>	K010074	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Fabric panels in conference room and therapy room treated to make them flame resitant. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The maintence director, housekeeping supervisor and HFA shall examine all areas of building to ensure all fabrics/curtains have been treated to make them flame resitant. What measures will be into place or what systemic changes will be made to ensure that the deficient practice does not recur: The</p>	05/02/2014
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	<p>Findings include:</p> <p>Based on observation with the maintenance director on 04/02/14 between 11:30 a.m. and 1:30 p.m., flame resistance labeling was not found on the 84 inch sheer fabric panel hanging over the dry erase board in the conference room and the four fabric panels draped around an area in the physical therapy room to create a private area. The maintenance director said at the time of observations, he had no evidence the materials were treated to make them flame resistant.</p> <p>3.1-19(b)</p>		<p>maintenance director and/or housekeeping supervisor shall make monthly rounds to ensure all fabrics/curtains have been treated to make them flame retardant. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The maintenance director shall report to quality assurance committee. The quality assurance committee shall provide suggestions if necessary. And, by what date the systemic changes will be completed: May 2, 2014</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 an electrical outlet in 1 of 10 hazardous areas. NFPA 101, 19.5.1 requires utilities to comply with Section 9.1. NFPA 101, 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice could affect visitors and 10 or more staff in the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/02/14 at 11:40 a.m., an electrical receptacle and light switch at the laundry entrance had a broken faceplate which exposed the interior parts of the switch. The maintenance director said at the time of observation, he was unaware of the exposed parts of the electrical switch .</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure extension</p>	K010147	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1) Broken faceplate in laundry room replaced.2)A) Extension cord for waters softener in service corridor removed. B) Power strip in room to power television was removed. C) Multi tap adapter at skilled nurses station removed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The maintenance director and HFA shall examine all areas of building to ensure all electrical faceplates/covers are not broken, power strips are being used appropriately and no multi tap adapters are being used. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director shall conduct monthly rounds to ensure electrical faceplates/covers are not broken, power strips are being used appropriately and no multi tap adapters are being used. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</p>	05/02/2014			

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	<p>cords including powerstrips and nonfused multiplug adapters were not used as a substitute for fixed wiring in 3 of 13 smoke compartments. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. 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 affects staff, visitors, and 20 or more residents in the skilled, main dining room, and Fountain smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/02/14 between 11:30 a.m. to 1:30 p.m., the following was noted:</p> <ul style="list-style-type: none"> <li>a. A water softener in the service corridor mechanical room was plugged into an extension cord for power;</li> <li>b. A power strip extension cord was located at the head of the bed in resident room 64 to power the television;</li> <li>c. A multi tap adapter was plugged into an outlet at the skilled nurses station to charge medical equipment batteries.</li> </ul> <p>The maintenance director acknowledge the aforementioned conditions at the time</p>		<p>program will be put into place: The maintenance director shall report to quality assurance committee. The quality assurance committee shall provide suggesstions if necessary. And, by what date the systemic changes wil be completed: May 2, 2014</p>				

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	of observation.  3.1-19(b)			