

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155178	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2012
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
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K0000	<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: 03/13/12</p> <p>Facility Number: 000094 Provider Number: 155178 AIM Number: 100290310</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center - Fountainview 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)</p>	K0000	<p>The preparation, submission and implementation of this plan of correction does to constitute an admission of our agreement with the facts and/or conclusions as set forth in the survey report. Our plan of correction is prepared and executed solely to continuously improve the quality of care and to comply with all applicable local, state and federal regulatory requirements.</p> <p>Given the scope and severity of the deficiency statements, we respectfully request a desk review of our compliance.</p> <p style="text-align: right;">William R Watson II, LHFA, FACHCA Executive Director 03/29/2012</p>	

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>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. Currently there are no smoke detectors in the resident rooms. The facility has a capacity of 130 and had a census of 115 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/16/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0021 SS=D	<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 1 of 3 kitchen corridor doors was held open only by a device which would allow it to close automatically upon activation of the fire alarm system. This deficient practice was not in a resident care area but could affect any number of staff.</p> <p>Finding include:</p> <p>Based on observation with the Maintenance Supervisor on 03/13/12 at 3:31 p.m., the corridor door entering the kitchen dish room was propped open with a wooden door wedge. This was confirmed by the Maintenance</p>	K0021	<p><b>K-021</b> It is the policy of this provider to hold open doors only by devices arranged to automatically close the doors when the fire detection system is activated. <u>1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</u> All "wooden wedges" used to hold doors open were removed and disposed of. <u>2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?</u> None were so identified. All "wooden wedges" used to hold doors open were removed and disposed of. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> Kitchen</p>	04/02/2012			

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	Supervisor at the time of observation.  3.1-19(b)		staff were re-inserviced on the prohibition of propping doors open by any means to include the use of "wooden wedges." The contractor in charge of the kitchen services will be directed to discipline up to and including discharge any employee(s) responsible for propping doors open. <u>4. How the corrective actions will be monitored to ensure that the alleged deficient practice will nor recur, i.e., what quality assurance program will be put into place?</u> Once daily M-F, the Maintenance Director or designee will visually check to verify no doors are propped open. If doors are found to be propped, the contractor in charge of the kitchen services will be directed to discipline up to and including discharge any employee(s) responsible for propping doors open. Monthly a report of the findings will be presented to the QA&A committee, who shall make recommendations regarding the frequency and form of continued monitoring. [See attach: K-021]		

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K0025 SS=D	<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 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect any number of staff.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 03/13/12 at 12:38 p.m., there is a two foot by two foot section and a two foot by four foot section of drywall missing from the ceiling in the Maintenance shop. Based on an interview with the Maintenance</p>	K0025	<p><b>K-025</b> It is the policy of this provider to maintain the integrity of smoke barriers in accordance with the appropriate application. <u>1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</u> Residents were not identified as being affected. A plumbing repair resulted in the removal of the drywall from the ceiling in a non resident area. The plumbing repair was complete and the drywall was replaced on the ceiling with 5/8" drywall single thickness resulting in 30 minute fire resistance. <u>2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?</u> None were so identified. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> Drywall</p>	03/23/2012			

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	<p>Supervisor at the time of observation, the drywall was removed to make repairs to plumbing lines above the ceiling. He stated he intended to make access panels instead of replacing the drywall.</p> <p>3.1-19(b)</p>		<p>is not routinely removed from walls or ceiling except in the circumstance where the drywall is compromised. There is no further action to conduct as the replacement of the missing section once accomplished eliminates the issue. <u>4. How the corrective actions will be monitored to ensure that the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?</u></p> <p>Drywall is not routinely removed from walls or ceiling except in the circumstance where the drywall is compromised. There is no further action to conduct as the replacement of the missing section once accomplished eliminates the issue. A report of the incident will be presented to the QA&amp;A committee, who shall make recommendations regarding the frequency and form of continued monitoring. [see attach: K-025]</p>		

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K0027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 3 of 8 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect four of nine smoke compartments.</p> <p>Finding include:</p> <p>Based on observations with the Maintenance Supervisor on 03/13/12 from 2:04 p.m. to 2:23 p.m., the smoke barrier doors on</p>	K0027	<p><b>K-027</b> It is the policy of this provider to maintain the integrity of smoke barriers in accordance with the appropriate application. <u>1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</u> Residents were not identified as being affected. During the inspection the doors which did not close correctly were adjusted to assure they closed at the appropriate rate and sealed appropriately as to maintain the integrity of the smoke compartment. <u>2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?</u> None were so identified. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> Weekly inspections, with corrective action if the door fails to close at the</p>	03/16/2012			

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	<p>Unit C, center hall and Unit C, hall 3 were recently painted and did not close completely leaving a five eights inch gap and a one half inch gap respectively; the bottom half of the smoke barrier doors entering the Therapy gym had a one fourth inch gap between the doors when closed.</p> <p>Measurements were provided by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p>		<p>expected rate and seals the door as appropriate. <u>4. How the corrective actions will be monitored to ensure that the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?</u> A report of the weekly inspections will be presented to the QA&amp;A committee, who shall make recommendations regarding the frequency and form of continued monitoring. [See atch: K-027a&amp;b]</p>		

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K0038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 exit discharge paths was readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for buildings shall comply with Chapter 7. LSC Section 7.2.5.4 requires a ramp with a rise greater than 6 inches shall have handrails. LSC Section 7.2.2.4.2, Exception #3 states existing ramps shall be permitted to have a handrail on one side only. This deficient practice could affect residents evacuated through the Therapy gym swimming pool exit in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/13/12 at 2:35 p.m., the Therapy gym swimming pool exit discharge sidewalk/ramp lacked a handrail. Based on an interview with the Maintenance Supervisor at the time of observation, he</p>	K0038	<p><b>K-038</b> It is the policy of this provider to maintain exit discharge paths readily accessible at all times. <u>1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</u> Residents were not identified as being affected. <u>2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?</u> None were so identified. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> The facility will pursue the installation of a hand rail along the ramp. Bids will be let and installation should be complete by 04/12/2012. <u>4. How the corrective actions will be monitored to ensure that the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?</u> Once the handrail is installed, no further action would benecessary and the alleged deficiency is eliminated. [see atch: K-038]</p>	04/12/2012			

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	<p>confirmed the rise in the sidewalk from the street to the building was two feet and it was a ramp.</p> <p>3.1-19(b)</p>			

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K0045 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to ensure the failure of any single fixture or bulb would not leave the area in darkness at 2 of 3 Therapy gym exits. This deficient practice could affect any number of residents evacuated through the main entrance and the swimming pool exit in the event of an emergency.</p> <p>Finding include:</p> <p>Based on observations with Maintenance Supervisor on 03/13/12 from 2:36 to 2:45 p.m., the exterior exit discharge from the Therapy gym main entrance and the swimming pool exit were equipped with a single light fixture with a single bulb. This was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p>	K0045	<p><b>K-045</b> It is the policy of this provider to maintain exit discharge paths readily accessible and appropriately illuminated at all times. <u>1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</u> Residents were not identified as being affected. <u>2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?</u> None were so identified. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> The provider will pursue the installation of appropriate lighting along the discharge paths identified. Bids will be let and installation to be complete by 04/12/2012. <u>4. How the corrective actions will be monitored to ensure that the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?</u> Once the lighting is installed, no further action would be necessary</p>	04/12/2012			

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	<p>2. Based on observation and interview, the facility failed to provide continuous illumination for 1 of 3 Therapy gym exit discharge paths that could not be controlled by a light switch. LSC Sections 7.8.1.2 requires continuous illumination during the time the conditions of occupancy require the means of egress be available for use. This deficient practice could affect any resident evacuated through the Therapy gym swimming pool exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/13/12 at 2:40 p.m., the emergency exterior light from the Therapy gym swimming pool exit was controlled by a light switch. This was confirmed by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		and the alleged deficiency. [See attch: K-045a&b]		

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K0046 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>Based on observation, record review and interview; the facility failed to ensure 3 of 3 emergency light fixtures of at least 1½ hour duration were tested monthly and annually in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment requires requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. In addition, NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient</p>	K0046	<p><b>K-046</b> It is the policy of this provider to maintain and inspect battery operated exit lights. <u>1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</u> Residents were not identified as being affected. <u>2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?</u> None were so identified. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> The provider will inspect and maintain the battery operated exit lights monthly and annually as required. Records will be kept electronically. <u>4. How the corrective actions will be monitored to ensure that the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?</u> As the monthly inspection/maintenance is performed by the maintenance director, a copy of the electronic form will be submitted monthly to the QA&amp;A committee, for review and recommendation. The committee will make</p>	04/02/2012			

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	<p>practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 03/13/12 at 12:05 p.m., a battery operated emergency task light was observed in the Maintenance shop. Based on an interview with the Maintenance Supervisor during record review at 12:07 p.m. on 03/13/12, there was a battery operated emergency light in the housekeeping storage room and the Therapy gym. A written record of the monthly function tests and an annual test for the battery operated emergency lights was not available for review.</p> <p>3.1-19(b)</p>		<p>recommendations as it sees fit to maintain compliance. [see attach: K046]</p>		

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K0062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure cubicle curtains installed in 1 of 9 residents rooms in Unit C, hall 3 and 1 of 1 shower rooms in Unit C, center hall were in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Because of the lack of cubicle curtain and sprinkler location coordination which may obstruct the sprinkler spray onto the fire or may shield the heat from the sprinkler, this deficient practice could affect any resident in the Unit C hall shower room and 2 residents in resident room 217.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 03/13/12 from 2:03 p.m. to 2:15 p.m., one of two cubicle curtains in resident room 217 and one of four shower curtains in the Unit C</p>	K0062	<p><b>K-062</b> It is the policy of this provider to maintain and inspect the automatic sprinkler system on a continuous and ongoing basis. <u>1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</u> Residents were not identified as being affected. <u>2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?</u> None were so identified. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> Such curtains as were identified were immediately removed from service and replaced with curtains with the required mesh. HCSG environmental services personnel were educated regarding the requirement for the 1/2" mesh of at least 18" in length below the deflector affixed to the sprinkler head in areas protected by an automatic sprinkler. <u>4. How the corrective actions will be monitored to ensure that the alleged deficient practice will nor</u></p>	03/16/2012			

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	<p>shower room lacked 1/2 inch diagonal mesh or a 70 percent open weave top panel extending 18 inches below the sprinkler deflector. This was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p>		<p><u>recur, i.e., what quality assurance program will be put into place?</u> At least monthly, inspection/maintenance will be performed to assure that all curtains meet the requirement of mesh top. This report will be submitted monthly to the QA&amp;A committee, for review and recommendation. The committee will make recommendations as it sees fit to maintain compliance.</p>	

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K0064 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 1 of 1 Activity room fire extinguisher and 1 of 2 Unit C, center hall fire extinguishers requiring a 12 year hydrostatic test were emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect any residents in the Activity room and any number of the 19 resident on C wing center hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/13/12 from 12:45 p.m. to 2:06 p.m., the maintenance tag on the Activity room fire extinguisher indicated the last six year test was completed August 2005 and the maintenance tag on the Unit C, center hall fire extinguisher near resident room 217 indicated the</p>	K0064	<p><b>K-064</b> It is the policy of this provider to maintain and inspect portable fire extinguishers on a continuous and ongoing basis, including hydrostatic testing.</p> <p><u>1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</u> Residents were not identified as being affected.</p> <p><u>2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?</u> None were so identified.</p> <p><u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> Such extinguishers as were identified (2) were immediately removed from service and replaced with units with a current hydrostatic test and 6 yr maintenance. Fire extinguisher vendor service staff were advised of the requirement for hydrostatic testing and 6 yr maintenance of the fire extinguisher vessel and directed to replace and maintain the inventory of extinguishers in</p>	03/16/2012			

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	<p>last six year test was February 2003. This was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p>		<p>house in a current status at all times or face revocation of the service contract.</p> <p><u>4. How the corrective actions will be monitored to ensure that the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?</u> At least monthly, inspection/ maintenance will be performed by the maintenance director to assure that all fire extinguishers are charged and within the requirements of hydrostatic testing. This report will be submitted monthly to the QA&amp;A committee, for review and recommendation. The committee will make recommendations as it sees fit to maintain compliance. [see atch: K 064]</p>		

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K0069 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect any resident in the dining room and kitchen staff in the event of an emergency.</p> <p>Findings include:</p> <p>Based on record review with Maintenance Supervisor on 03/13/12 at 2:52 p.m., the Allied Safety Services Inc. inspection form indicated "Recommend system upgrade. System tank due for Hydrostatic test. Stove not properly protected." Based on interview with the Maintenance Supervisor at 12:00 p.m., a hydrostatic test had not been done.</p>	K0069	<p><b>K-069</b> It is the policy of this provider to maintain and inspect the automatic sprinkler system on a continuous and ongoing basis, including the range hood suppression system.. <u>1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</u> Residents were not identified as being affected. <u>2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?</u> None were so identified. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> The vendor was contacted and the upgrade recommended for the system was contracted for. The work is expected to be completed by 04/12/2012. <u>4. How the corrective actions will be monitored to ensure that the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?</u> Once the system upgrade is installed, no further action would be necessary and the alleged deficiency is eliminated. [see atch: K069a&amp;b]</p>	04/12/2012			

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	<p>3.1-19(b)</p> <p>2. Based on observation, record review and interview, the facility failed to ensure 1 of 1 pieces of cooking equipment such as a gas stove was protected by fire extinguishing equipment in the kitchen. LSC, Section 19.3.2.6 requires cooking facilities to be in compliance with Section 9.2.3 which requires commercial cooking equipment to be in compliance with NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, at Section 7-1.2 requires cooking equipment that produces grease-laden vapors such as but not limited to deep fat fryers, ranges, griddles, broilers, woks, tilting skillets, and braising pans shall be protected by fire extinguishing equipment. This deficient practice could affect kitchen staff and any number of residents in the main dining room.</p> <p>Findings include:</p> <p>Based on record review with</p>						

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	<p>Maintenance Supervisor on 03/13/12 at 2:52 p.m., the Allied Safety Services Inc. inspection form indicated "Stove not properly protected." Based on observation with the Maintenance Supervisor at 3:35 p.m. on 03/13/12, the kitchen gas stove was located under the kitchen hood but there was no nozzle coverage from the hood extinguishing system above the stove. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>				

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K0130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview, the facility failed to ensure 1 of 2 boilers had a current inspection certificate to ensure the boiler was in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of residents. This deficient practice affects any number of residents in the Therapy gym and any resident evacuated through the service hall.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor on 03/13/12 at 3:00 p.m., the boiler with the registration number 272745 had a Certificate of Inspection that expired on 01/14/12. Based on interview with the Director of Maintenance at the time of record review, no other documentation was available for review.</p>	K0130	<p><b>K-130</b> It is the policy of this provider to maintain a current inspection of any boilers operating in the facility on a continuous and ongoing basis. <u>1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</u> Residents were not identified as being affected. <u>2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?</u> None were so identified. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> The insurance vendor was contacted and the inspection recommended for the boiler was contracted for. The work was completed on 03/28/2012. <u>4. How the corrective actions will be monitored to ensure that the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?</u> Once the inspection is completed, no further action would be necessary and the alleged deficiency is eliminated. [see attach: K 130]</p>	03/28/2012			

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K0143 SS=D	<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> <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. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 areas used for transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect 2 resident in resident room 205.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 03/13/12 at 1:55 p.m., a large liquid oxygen container was located near the TV in resident</p>	K0143	<p><b>K-143</b> It is the policy of this provider to transfer oxygen in an area separated from patient occupancy by at least a one hour fire resistive barrier. <u>1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</u> The oxygen container from which oxygen was alleged to have been transferred, found to be located in the resident area was relocated to the designated oxygen storage/transfer area. This vessel was placed in the residents' room in error. The Hospice provider who placed it in the room was notified and advised of the requirement to store and transfer oxygen ONLY in the designated area. <u>2. How other residents having the potential to be affected by the same alleged deficient</u></p>	04/02/2012

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	<p>room 205. Based on an interview with the DON at 1:57 p.m. on 03/13/12, the liquid oxygen container has been stored there for about two weeks. It was brought in by Hospice and belongs to the resident. She stated when the small portable unit need transfilling, the transfilling takes place in resident room 205.</p> <p>3.1-19(b)</p>		<p><u>practice will be identified and what corrective action(s) will be taken?</u> None were so identified.</p> <p><u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> The Hospice provider who placed it in the room was notified and advise of the requirement to store and transfer oxygen ONLY in the designated area.</p> <p><u>4. How the corrective actions will be monitored to ensure that the alleged deficient practice will nor recur, i.e., what quality assurance program will be put into place?</u> At least weekly, the maintenance director or designee will audit 3 rooms for the inappropriate presence of oxygen containers. Those found to be placed incorrectly will be relocated to the appropriate area. A report of the findings will be presented to the QA&amp;A committee monthly for review and recommendation. [see atch: K143]</p>		

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K0144 SS=C	<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>Based on interview and record review, the facility failed to ensure the off site fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <p>a) Liquid petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply</p>	K0144	<p><b>K-144</b> It is the policy of this provider to inspect weekly and exercise the emergency generator <u>1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</u> The emergency generator was inspected and exercised weekly and was so documented. At no time in the past has the natural gas had an outage at this facility, built circa 1969. A letter was on file and acceptable previous to this inspection. These facts notwithstanding, the facility has obtained a letter from the Natural Gas provider stating the elements demanded by the surveyor. <u>2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?</u> None were so identified. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> The revised letter needs no further action to maintain compliance. <u>4. How the corrective actions will be monitored to ensure that the alleged deficient practice will nor</u></p>	04/02/2012			

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	<p>system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source.</p> <p>CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:</p> <ol style="list-style-type: none"> <li>1. A statement of reasonable reliability of the natural gas delivery.</li> <li>2. A brief description that supports the statement regarding the reliability.</li> <li>3. A statement that there is a low probability of interruption of the natural gas.</li> <li>4. A brief description that supports the statement regarding the low probability of interruption,</li> <li>5. The signature of a technical person from the natural gas provider.</li> </ol> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview with the</p>		<p><u>recur, i.e., what quality assurance program will be put into place?</u></p> <p>The revised letter needs no further action to maintain compliance. This item will be presented to the QA&amp;A committee for review and recommendation. [see attach: K144]</p>				

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Maintenance Supervisor on 03/13/12 at 11:18 a.m., the fuel source for the emergency generator was natural gas. Additionally, based on record review, the facility did have a letter from their natural gas provider (NIPSCO) dated March 30, 2009 but the letter did not include all the items above required for a letter confirming the reliability of a natural gas fuel source for an emergency generator. The letter lacked supporting statements of reliability of natural gas and low probability of interruption of the natural gas service. This was acknowledged by the Maintenance Supervisor during the time of record review.</p> <p>3.1-19(b)</p>				

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K0147 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>Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords such as an extension cord was not used as a substitute for fixed wiring. 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 could affect 2 residents in resident room 131 and any resident near the copier room or evacuated through the service hall in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observations with the Maintenance Supervisor on 03/13/12 between 1:05 p.m. and 2:50 p.m., extension cords were noted in the following locations: a. a regular light weight extension cord was plugged in and providing</p>	K0147	<p><b>K-147</b> It is the policy of this provider to prohibit the use of flexible extension cords in lieu of fixed structural wiring. <u>1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</u> All such cords were removed from service. Residents, families and staff have been reminded that extension cords cannot be used in the facility. <u>2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?</u> None were so identified. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> During routine environmental rounds, the maintenance director will check visually in a minimum of 5 rooms and verify no extension cords are in use. <u>4. How the corrective actions will be monitored to ensure that the alleged deficient practice will nor recur, i.e., what quality assurance program will be put into place?</u> The results of the rounds will be presented to the QA&amp;A committee for review and recommendation. [see attach: K147]</p>	04/02/2012			

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	<p>power for a TV in resident room 131</p> <p>b. a regular heavy weight extension cord was observed penetrating a ceiling tile with one end hanging next to a receptacle in the service hall. Based on an interview with the Maintenance Supervisor at the time of observation, the extension cord provides power for heat tape that is wrapped around a gutter drain to prevent it from freezing in the winter.</p> <p>c. a power strip was plugged into another power strip in the copier room. This was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p>				