

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2016
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NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/16/16</p> <p>Facility Number: 000501 Provider Number: 155635 AIM Number: 100266260</p> <p>At this Life Safety Code survey, Grace Village Health Care Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building consisting of halls 1, 2, 3, 5 and the main dining room was surveyed with Chapter 19 Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type III (211) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and in areas open to the corridors. Battery operated smoke detectors were installed in all resident</p>	K 0000		
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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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K 0011 SS=E Bldg. 01	<p>rooms in the original building. The facility has a capacity of 89 and had a census of 83 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered included a detached garage used for storage of maintenance equipment and parts with the portion of the building used as a maintenance garage, and a detached shed used for storage of parts and lawn equipment. The facility had a fire pump room that was sprinklered.</p> <p>Quality Review completed on 08/22/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 "Hall 5 Entering F Hall" fire barriers to a nonconforming occupancy was protected</p>	K 0011	<p>I. <u>Corrective action taken for affected residents:</u> No specific residents have been affected.</p> <p>II. <u>How other residents potentially affected will be identified:</u> Surveyor noted that staff and 16</p>	11/30/2016

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	<p>by a two hour fire rating. LSC 19.1.2.1 states sections of health care facilities shall be permitted to be classified as other occupancies, provided that they meet all of the following conditions:</p> <ol style="list-style-type: none"> 1. They are not intended to serve health care occupants for purposes of housing, treatment, or customary access by patients incapable of self-preservation. 2. They are separated from areas of health care occupancies by construction having a fire resistance rating of not less than 2 hours. <p>This deficient practice could affect all staff and up to 16 patients.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services on 08/16/16 at 2:06 p.m., the wall which separates the Hall 5 and Hall F, a nonconforming occupancy, did not have any rating tags on either fire doors which open to Assisted Living. Based on interview at the time of observation, the Director of Environmental Services acknowledged the aforementioned condition and confirmed the location of the occupancy separation.</p>		<p>residents on Hall 5 could potentially be affected. Administration wishes to note that numerous other means of egress from the location described are available to all of the staff and residents.</p> <p>III. Measures implemented to ensure deficiency does not recur: The set of doors indicated in the report will be replaced with new door slabs with affixed tags confirming a 90 minute fire rating. Maintenance personnel have been in-serviced on the code pertaining to the doors cited during the survey. IV. <u>How corrective measures will be monitored:</u> This set of doors will be added to the regular PM schedule to be checked and documented weekly for proper gaps and operation. The Director of Environmental Services (DES) will report findings from the weekly testing to the QA Committee which meets quarterly. Any non-compliance found will result in additional corrections and extended monitoring to be determined by the QA Committee. A temporary waiver is submitted with this plan of correction to provide for the time needed to acquire custom sized fire doors.</p>				

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K 0017 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5</p> <p>Based on observation, the facility failed to ensure 1 of 1 Hall 5 corridors was capable of resisting smoke. This deficient practice could affect staff and up to 16 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services on 08/16/16 at 2:16 p.m., the corridor near resident room door 427 was not smoke resistant due to a three inch by two inch penetration.</p> <p>Based on interview at the time of observation, the Director of</p>	K 0017	<p>I. <u>Corrective action taken for affected residents:</u> No residents were affected. II. <u>How other residents potentially affected will be identified:</u> There were no fires to potentially affect staff or residents prior to completion of the corrective action.</p> <p>III. <u>Measures implemented to ensure deficiency does not recur:</u> As provided for under Exception #6, an electronically supervised automatic heat detector was installed and tested by the facility's fire alarm system contractor in the "Servery" room which opens into a dining room that opens to the corridor. Maintenance personnel were</p>	08/17/2016

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K 0025 SS=D Bldg. 01	<p>Environmental Services acknowledged the aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barrier was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall</p>	K 0025	<p>in-serviced on the code requiring a device in this kind of space.</p> <p>IV. <u>How corrective measures will be monitored:</u> The contractor who installed the new heat detector is also contracted to provide all required periodic testing and servicing of all components of the electronically supervised fire alarm system. The newly added smoke detector is recorded on the inventory of all devices to be tested by the contractor. The DES will review all reports provided by the contractor after required inspections to ensure all devices are documented to have passed. Any instances of non-compliance will be reported to the QA Committee which meets quarterly. The QA Committee will determine if any further corrective actions or monitoring are necessary.</p> <p>I. <u>Corrective action taken for affected residents:</u> No residents were affected. II. <u>How other residents potentially affected will be identified:</u> No residents beyond those mentioned in the report</p>	09/09/2016

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K 0029 SS=E Bldg. 01	<p>be continuous from an outside wall to an outside wall. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations with the Director of Environmental Services on 08/16/16 at 2:29 p.m., a three inch by two inch ceiling penetration in the Staff Break room. Based on interview at the time of observation, the Director of Environmental Services acknowledged and provided the measurement for the unsealed penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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</p>		<p>were potentially affected. No fire incidents occurred prior to the completion of corrective measures. III. <u>Measures implemented to ensure deficiency does not recur</u>: The penetration in the transportation office was sealed with an approved fire proof material to prevent the passage of smoke. Maintenance personnel were in-serviced on the applicable code regarding penetrations in ceiling smoke barriers. IV. <u>How corrective measures will be monitored</u>: The Director of Environmental Services (DES), or his designee, will inspect rooms in which any mechanical work is completed that involves the creation of new penetrations on a weekly basis for 60 days. If no incidents of non-compliance are found, those inspections will be conducted on a monthly basis for at least an additional 6 months. The DES will report findings from the inspections to the QA Committee which meets quarterly. Any non-compliance found will result in additional corrections and extended monitoring to be determined by the QA Committee.</p>		

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	<p>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 the corridor door to 1 of 1 Hall 5 Wheelchair storage room greater than 50 square feet, a hazardous area, was provided with a self-closer and would positively latch into the frame. This deficient practice could affect staff and up to 16 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services on 08/16/16 at 2:18 p.m., the Hall 5 Wheelchair storage room contained ten large cardboard boxes, twelve mattresses, wood shelving, and other miscellaneous storage. The corridor door did not have a self-closing device installed. Based on interview at the time of observation, the Director of Environmental Services acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 fuel-fired Hall 5</p>	K 0029	<p>I. <u>Corrective action taken for affected residents</u>: No residents were affected. II. <u>How other residents potentially affected will be identified</u>: No residents or staff were affected prior to the completion of corrective measures. III. <u>Measures implemented to ensure deficiency does not recur</u>: A self-closer was installed on the door to the Hall 5 wheelchair storage room. A coordinating device was installed on the set of double doors to the Hall 5 mechanical room. Maintenance personnel were in-serviced on the applicable code regarding door closing requirements on rooms that contain hazardous areas. IV. <u>How corrective measures will be monitored</u>: The Director of Environmental Services (DES), or his designee, will inspect both sets of doors weekly for 60 days to ensure proper operation. If no incidents of non-compliance are found, those inspections will be conducted on a monthly basis included on the routine door inspection included on the monthly preventative maintenance (PM) checklist. The DES will report findings from the inspections for the next six</p>	09/09/2016

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K 0044 SS=F Bldg. 01	<p>Electrical/Boiler room, a hazardous area, would latch into the frame without an impediment. This deficient practice could affect staff and up to 16 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services on 08/16/16 at 2:21 p.m., the Hall 5 Electrical/Boiler room contained a set of corridor double doors. One door had an astragal. No coordinating device was installed to prevent the non-astragal door from closing first. Based on interview at the time of observation, the Director of Environmental Services acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 2 of 5 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition</p>	K 0044	<p>months to the QA Committee which meets quarterly. Any non-compliance found will result in additional corrections and extended monitoring to be determined by the QA Committee.</p> <p>I. <u>Corrective action taken for affected residents:</u> No residents were affected. II. <u>How other residents potentially affected will be identified:</u> No residents or staff were affected prior to the corrective adjustments made to the fire door hardware. III. <u>Measures implemented to ensure deficiency does not recur:</u></p>	08/17/2016

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K 0052 SS=E Bldg. 01	<p>NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect staff and all residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services on 08/16/16 at 1:53 p.m. then again at 2:06 p.m., the Health Care Dining room fire doors failed to close and latch when tested. Then again, the "Hall 5 Entering F Hall" fire barrier failed to close and latch when tested. Based on interview at the time of each observation, the Director of Environmental Services acknowledged each aforementioned condition and confirmed each set of doors were fire doors.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with</p>		<p>The hardware on both the HC dining room doors and the fire doors between Hall 5 and F Hall were adjusted and tested to latch positively while the inspector was on-site. Maintenance personnel were in-serviced on the applicable code regarding the positive latching requirement on all fire doors. IV. <u>How corrective measures will be monitored:</u> The Director of Environmental Services (DES), or his designee, will inspect and adjust (if needed) both sets of doors weekly for 60 days to ensure proper operation. If no incidents of non-compliance are found, those inspections will be conducted on a monthly basis included on the routine door inspection included on the monthly preventative maintenance (PM) checklist. The DES will report findings from the inspections for the next six months to the QA Committee which meets quarterly. Any non-compliance found will result in additional corrections and extended monitoring to be determined by the QA Committee.</p>				

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	<p>applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect staff and at least 10 residents.</p> <p>Findings include:</p> <p>Based on record review with the Director of Environmental Services on 08/16/16 at 10:54 a.m., the annual fire alarm inspection report from Shambaugh and Son LP on 05/26/16 indicated that "#2 unable to access." Based on phone interview, Shambaugh and Son LP confirmed to the Director of Environmental Services that the technician was unable to access the elevator smoke detector.</p> <p>3.1-19(b)</p>	K 0052	<p>I. <u>Corrective action taken for affected residents</u>: No residents were affected. II. <u>How other residents potentially affected will be identified</u>: No residents or staff were affected prior to the correction made. III. <u>Measures implemented to ensure deficiency does not recur</u>: Facility maintenance personnel have obtained a copy of the "Fireman's"key to operate the elevator which was needed for the smoke detector in the shaft to be inspected. The facility's alarm system contractor completed the inspection and servicing of the smoke detector equipment in the elevator shaft. Maintenance personnel were in-serviced on the applicable code. IV. <u>How corrective measures will be monitored</u>: The alarm system contractor will complete future required inspections of the elevator shaft smoke detector (which they had previously known about and identified) along with the inspection of all other smoke detectors and system components that they have completed routinely according to Code and per contract. The Director of Environmental Services (DES),or his designee, will review contractor's inspection documentation after each required inspection on a permanent basis to ensure that no devices have been skipped</p>	09/09/2016

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K 0075 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Hall 2 soiled linen room and 1 of 1 Room 225 containing more than 64 gallons of soiled linen, a hazardous area, was provided with a self-closer and would positively latch into the frame. This deficient practice could affect staff and up to 30 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services on 08/16/16 at 3:13 p.m. then again at 3:17 p.m., the</p>	K 0075	<p>due to lack of access or any other reason. The DES will report findings of the documentation reviews for the next six months to the QA Committee which meets quarterly. Any non-compliance found will result in additional corrections and extended monitoring to be determined by the QA Committee.</p> <p>I. <u>Corrective action taken for affected residents:</u> No residents were affected. II. <u>How other residents potentially affected will be identified:</u> No residents or staff were affected prior to the corrections made. III. <u>Measures implemented to ensure deficiency does not recur:</u> The door latching mechanism was adjusted and tested to positively latch into the door frame on the Hall 2 soiled linen room. Room 225 is a resident room that was vacant and in the process of being remodeled at the time of inspection. Nursing staff members had left the soiled linen</p>	09/09/2016

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K 0130	Hall 2 soiled utility room failed to latched when tested. Then again, Room 225 was used for storage of over 64 gallons of soiled linen. The corridor door to Room 225 did not have a self-closing device installed. Based on interview at the time of each observation, the Director of Environmental Services acknowledged each aforementioned condition. 3.1-19(b) NFPA 101		containers in the room for convenience, which it would not normally be stored in. Rather than implementing a door closer, the soiled linen carts were removed from the room and will not be placed there again. Nursing personnel have been instructed that soiled linen carts may not be stored in a vacant resident room. Maintenance personnel were in-serviced on the applicable code regarding soiled linen storage and hazardous areas. IV. <u>How corrective measures will be monitored:</u> The Hall 2 soiled linen room door will be included on a weekly inspection PM checklist for 60 days to ensure that it continues to positively latch into the door frame when pulled shut by the automatic closer. It will be included on a monthly inspection PM checklist thereafter provided that it has been found to be operating properly during each of the weekly checks. Room 225 will also be included in the weekly inspections to ensure no soiled linen carts have been placed in the room. The DES will report findings of the inspections for the next six months to the QA Committee which meets quarterly. Any non-compliance found will result in additional corrections and extended monitoring to be determined by the QA Committee.		

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SS=E Bldg. 01	MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 1. Based on observation and interview, the facility failed to ensure the penetration in 1 of 5 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.	K 0130	I. <u>Corrective action taken for affected residents</u> : No residents were affected. II. <u>How other residents potentially affected will be identified</u> : No residents or staff were affected prior to the corrections made. III. <u>Measures implemented to ensure deficiency does not recur</u> : The two small penetrations the fire barrier identified were filled in with a fire proof caulk and tagged. Installation dates are written in permanent ink on all battery powered smoke detectors. All smoke detectors used are powered by a 10 year rated non-replaceable lithium battery which is indicated on the face of each smoke detector. The existing smoke detectors were installed in June 2012 and are nowhere near the end of their life expectancy. Weekly testing of the smoke detectors is conducted. Additionally, the alarms will sound to alert staff or anyone else in audible range when the batteries become weak enough that they need replacement. The weekly testing log will include a box to indicate whether or not the smoke detector is due for replacement when it is checked. Maintenance personnel were in-serviced on the applicable code and on the smoke detector replacement procedure. IV. <u>How corrective measures will be monitored</u> : The DES, or his designee, will inspect	09/02/2016
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	<p>b. It shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect staff and up to 16 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Environmental Services on 08/16/16 at 4:12 p.m., a three quarter inch penetration around cable and another quarter inch penetration was discovered in the "Hall 5 Entering F Hall" fire barrier. Based on interview at the time of observation, the Director of Environmental Services acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a battery replacement program was provided to ensure 40 of 40 single station smoke detectors would operate. This deficient practice could affect up to 77 residents.</p> <p>Findings include:</p> <p>Based on record review with the Director of Environmental Services on 08/16/16 at 11:00 a.m., the "PM Sheet for 1st Alert</p>		<p>all fire barriers on a weekly basis for 60 days for any new unprotected penetrations. If no incidents of non-compliance are found, those inspections will be conducted on a monthly basis for at least an additional 6 months. The DES, or his designee, will review the weekly smoke detector testing log weekly for 60 days to ensure any smoke detector requiring replacement has been completed and documented. Documentation review on battery testing/replacement will continue on a monthly basis for at least 6 months thereafter. The DES will report findings of the inspections for the next six months to the QA Committee which meets quarterly. Any non-compliance found will result in additional corrections and extended monitoring to be determined by the QA Committee.</p>	

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K 0147 SS=E Bldg. 01	<p>Smoke Detectors" showed the devices were being tested weekly. No documentation was available providing information indicating a battery replacement. Based on interview at the time of record review, the Director of Environmental Services acknowledged the aforementioned condition and confirmed no other documentation is available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1</p> <p>1. Based on observation and interview, the facility failed to ensure 11 of 11 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, 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 and up to 18 residents.</p> <p>Findings include:</p>	K 0147	<p>I. <u>Corrective action taken for affected residents:</u> No residents were affected. II. <u>How other residents potentially affected will be identified:</u> There were no fires to potentially affect staff or residents prior to the completion of corrective actions for each of the findings. III. <u>Measures implemented to ensure deficiency does not recur:</u> The surge protector powering the refrigerator in the MDS office was removed. The multi-plug powering the surge protector in the Medical Records office was removed. Equipment has been moved such that it is able to be plugged directly into permanently wired outlets. All maintenance</p>	09/15/2016

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	<p>Based on observation with the Director of Environmental Services on 08/16/16 between 1:20 p.m. and 1:48 p.m., the following was discovered:</p> <p>a) two separate surge protectors were powering five separate surge protectors in the communications room.</p> <p>b) a surge protector was powering a coffee pot in the Payroll office</p> <p>c) a surge protector was powering a refrigerator in the Main Nurses' station medication room</p> <p>d) a surge protector was powering a refrigerator and an air conditioner in the ADON office</p> <p>e) a surge protector was powering a refrigerator in resident room 411</p> <p>Based on interview at the time of each observation, the Director of Environmental Services acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure electrical junction boxes in 2 of 9 attic smoke compartments observed was maintained in a safe operating condition. LSC 19.5.1 requires utilities 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, 1999 Edition, Article</p>		<p>personnel were in-serviced on the code indicated in the survey report regarding the prohibition of surge protectors supplying power to high amperage devices and surge protectors plugged into multi-plugs. Housekeepers were in-serviced to be on the lookout for non-permissible use of surge protectors. Nursing staff will also be reminded that equipment such as air conditioners, refrigerators and coffee pots may not be plugged into multi-plugs or other surge protectors. IV. <u>How corrective measures will be monitored:</u> The Director of Environmental Services (DES), or his designee, will inspect all offices, med rooms, nourishment rooms and resident rooms on a weekly basis for at least 60 days where refrigerators are in use to ensure that no new surge protectors have been introduced. If no incidents of non-compliance are found, those inspections will be conducted on a monthly basis for at least an additional 6 months. The DES will report findings from the inspections to the QA Committee which meets quarterly. Any non-compliance found will result in additional corrections and extended monitoring to be determined by the QA Committee.</p>	

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K 0000 Bldg. 03	<p>370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect staff.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services on 08/16/16 at 3:40 p.m. then again at 3:48 p.m., there was exposed wiring in a junction box without a cover near the Rehabilitation Entrance attic fire barrier. Then again, there was exposed wiring without a junction box near the Communications attic fire barrier. Based on interview at the time of observation, the Director of Environmental Services acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <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: 08/16/16</p> <p>Facility Number: 000501</p>	K 0000					

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	<p>Provider Number: 155635 AIM Number: 100266260</p> <p>At this Life Safety Code survey, Grace Village Health Care Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The Rehabilitation hall and Therapy was surveyed with Chapter 18 New Health Care Occupancies.</p> <p>The Rehabilitation addition to the facility, completed in 2007, was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and in areas open to the corridors. The new Rehabilitation Unit had hard wired smoke detectors in resident rooms. The facility has a capacity of 89 and had a census of 83 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered included a detached garage used for storage of maintenance equipment and parts with the portion of the building used as a maintenance</p>			

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K 0017 SS=E Bldg. 03	<p>garage, and a detached shed used for storage of parts and lawn equipment. The facility had a fire pump room that was sprinklered.</p> <p>Quality Review completed on 08/22/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.4, 18.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 1 Rehabilitation Servery room was separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by an automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient</p>	K 0017	<p>I. <u>Corrective action taken for affected residents</u>: No residents were affected. II. <u>How other residents potentially affected will be identified</u>: There were no fires to potentially affect staff or residents prior to completion of the corrective action. III. <u>Measures implemented to ensure deficiency does not recur</u>: As provided for under Exception #6, an electronically supervised automatic heat detector was installed and tested by the facility's fire alarm system contractor in the "Servery" room which opens into a dining room that opens to the corridor. Maintenance personnel were in-serviced on the code requiring a device in this kind of space. IV. <u>How corrective measures will be monitored</u>: The contractor who installed the new heat detector is</p>	09/09/2016			

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K 0018 SS=E Bldg. 03	<p>practice could affect staff and up to 12 residents</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services on 08/16/16 at 12:17 p.m., the Rehabilitation Servery room had a large serving window which was open to the corridor. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because the room was not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of observation, the Director of Environmental Services acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 Rehabilitation Dining room, 1 of 1</p>	K 0018	<p>also contracted to provide all required periodic testing and servicing of all components of the electronically supervised fire alarm system. The newly added smoke detector is recorded on the inventory of all devices to be tested by the contractor. The DES will review all reports provided by the contractor after required inspections to ensure all devices are documented to have passed. Any instances of non-compliance will be reported to the QA Committee which meets quarterly. The QA Committee will determine if any further corrective actions or monitoring are necessary.</p> <p>I. <u>Corrective action taken for affected residents:</u> No residents were affected. II. <u>How other</u></p>	09/09/2016	

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	<p>Rehabilitation clean linen room, 1 of 2 Rehabilitation Storage room corridor doors closed and positively latched into the door frame. This deficient practice could affect staff and up to 12 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services on 08/16/16 between 12:15 p.m. and 12:36 p.m., the following corridor doors contained manual latching hardware:</p> <p>a) the Rehabilitation Dining room storage room contained double doors that latched into each other but manually latched into the frame.</p> <p>b) the Rehabilitation clean linen room contained double doors that latched into each other but manually latched into the frame.</p> <p>c) the Rehabilitation Storage room #1 contained double doors that latched into each other but manually latched into the frame.</p> <p>Based on interview at the time of each observation, the Director of Environmental Services acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1</p>		<p><u>residents potentially affected will be identified:</u> The report identified 12 residents and staff that could potentially be affected in the event of a fire in that location. No fires broke out prior to the completion of corrective measures. III. <u>Measures implemented to ensure deficiency does not recur:</u> The three sets of double doors identified have been modified to ensure positive latching. One leaf of each set has been bolted so that it cannot be opened. The active leaf of each set latches positively into the fixed door. Maintenance personnel were in-serviced on the applicable code. IV. <u>How corrective measures will be monitored:</u> Latching mechanism will be tested weekly for 30 days to ensure proper operation. Inspections will be conducted monthly thereafter on an ongoing basis. The DES will report findings from the inspections for a period of not less than 6 months to the QA Committee which meets quarterly. Any non-compliance found will result in additional corrections as determined by the QA Committee.</p>	

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K 0025 SS=E Bldg. 03	<p>Rehabilitation Janitor ' s closet corridor doors did not have an impediment to latching. This deficient practice could affect staff and up to 12 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 08/16/16 at 12:01 p.m., the Director of Environmental Services acknowledged the corridor door to the Rehabilitation Janitor ' s closet had a door stop that prevented the corridor door from closing and latching into the door frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barrier was maintained to provide a one 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 could affect staff and at least 12 residents.</p>	K 0025	<p>I. <u>Corrective action taken for affected residents</u>: No residents were affected. II. <u>How other residents potentially affected will be identified</u>: No residents beyond those mentioned in the report were potentially affected. No fire incidents occurred prior to the completion of corrective measures. III. <u>Measures implemented to ensure deficiency</u></p>	09/09/2016
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K 0062 SS=E Bldg. 03	<p>Findings include:</p> <p>Based on observations with the Director of Environmental Services on 08/16/16 at 1:03 p.m., a four inch ceiling penetration around a tube of wires in the Transportation room.</p> <p>Based on interview at the time of observation, the Director of Environmental Services acknowledged and provided the measurement for the unsealed penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace 6 of 6 corroded sprinkler heads in the covered front entrance. LSC 9.7.5 requires all</p>			K 0062	<p><u>does not recur</u>: The penetration in the transportation office was sealed with an approved fire proof material to prevent the passage of smoke. Maintenance personnel were in-serviced on the applicable code regarding penetrations in ceiling smoke barriers. IV. <u>How corrective measures will be monitored</u>: The Director of Environmental Services (DES), or his designee, will inspect rooms in which any mechanical work is completed that involves the creation of new penetrations on a weekly basis for 60 days. If no incidents of non-compliance are found, those inspections will be conducted on a monthly basis for at least an additional 6 months. The DES will report findings from the inspections to the QA Committee which meets quarterly. Any non-compliance found will result in additional corrections and extended monitoring to be determined by the QA Committee.</p> <p>I. <u>Corrective action taken for affected residents</u>: No residents were affected. II. <u>How other residents potentially affected will be identified</u>: The location of the</p>		09/02/2016

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff up to 12 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services on 08/16/16 at 11:57 a.m., all the sprinkler heads were corroded in the covered front entrance. Based on interview at the time of observation, the Director of Environmental Services acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>sprinkler heads and the area they protect (an outside detached canopy constructed of masonry pillars and aluminum wrapped wood trusses, which is not required by Code to be sprinklered) is such that a fire in that location is unlikely to affect any building occupants due to multiple means of egress in opposite directions available as well as full smoke detection and sprinkler system within the building. III. <u>Measures implemented to ensure deficiency does not recur:</u> The sprinkler system install/maintenance contractor came onsite to inspect the corrosion observed by the LSC inspector. Code allows for light surface corrosion to exist on the heads provided it does not adversely affect the operation of the heads. The certified technician working for our contractor examined the heads and provided an expert opinion that they should not be affected by the observed corrosion and that replacement is not warranted. (Please see Attachment A) Maintenance personnel were in-serviced on the code requirement regarding corrosion on sprinkler heads. IV. <u>How corrective measures will be monitored:</u> The contractor who installs the replacement heads is also contracted to provide quarterly inspections, testing and servicing of all components of the facility's automatic sprinkler</p>	

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K 0070 SS=E Bldg. 03	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 space heater was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice could affect staff and up to 12 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services on 08/16/16 at</p>	K 0070	<p>system. The 6 under canopy sprinkler heads will be included in the inventory of system components maintained by the contractor. The DES will review all reports provided by the contractor after required inspections to ensure all devices are documented to have passed. Any instances of non-compliance will be reported to the QA Committee which meets quarterly. The QA Committee will determine if any further corrective actions or monitoring are necessary.</p> <p>I. <u>Corrective action taken for affected residents</u>: No residents were affected. II. <u>How other residents potentially affected will be identified</u>: All space heaters were removed (and none were in use as it is summer) so there was no potential for others to be affected. III. <u>Measures implemented to ensure deficiency does not recur</u>: Facility policy will be revised to prohibit employees from bringing in their own portable space heaters. Employees may only</p>	09/15/2016

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K 0147 SS=E Bldg. 03	12:22 p.m., a space heater was discovered in the Rehabilitation Front Entrance. Based on interview at the time of observation, the Director of Environmental Services was unable to provide documentation to confirm the space heater element did not exceed 212 degrees (100 degrees C). 3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the	K 0147	utilize a space heater that is obtained from the maintenance department. The maintenance department will only provide a space heater to an employee IF a make/model can be obtained which meets the standard of not exceeding 212 degrees Fahrenheit. Where portable space heaters are known to have been used by employees in the past, maintenance personnel will evaluate the situation and determine if a permanently mounted and wired heater could be installed. Maintenance personnel have been in-serviced on the code pertaining to the use of portable space heaters. <u>IV. How corrective measures will be monitored:</u> The DES, or his designee, will conduct a monthly inspection of employee offices and work spaces for a minimum of 6 months to ensure no outside portable space heaters have been introduced. A report of those inspection results will be presented to the QA Committee which meets quarterly. The QA Committee will determine what further corrective actions or monitoring are necessary if any instances of non-compliance are found. I. <u>Corrective action taken for</u>	09/15/2016	

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	<p>facility failed to ensure 1 of 1 multiplug and 1 of 1 surge protector flexible cord were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, 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 and up to 12 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services on 08/16/16 at 12:22 p.m. then again at 1:48 p.m., a surge protector was powering a refrigerator in the MDS office. Then again, a multiplug was powering a surge protector in the Medical Records office. Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p><u>affected residents</u>: No residents were affected. II. <u>How other residents potentially affected will be identified</u>: There were no fires to potentially affect staff or residents prior to the completion of corrective actions for each of the findings. III. <u>Measures implemented to ensure deficiency does not recur</u>: The surge protector powering the refrigerator in the MDS office was removed. The multi-plug powering the surge protector in the Medical Records office was removed. Equipment has been moved such that it is able to be plugged directly into permanently wired outlets. All maintenance personnel were in-serviced on the code indicated in the survey report regarding the prohibition of surge protectors supplying power to high amperage devices and surge protectors plugged into multi-plugs. Housekeepers were in-serviced to be on the lookout for non-permissible use of surge protectors. Nursing staff will also be reminded that equipment such as air conditioners, refrigerators and coffee pots may not be plugged into multi-plugs or other surge protectors. IV. <u>How corrective measures will be monitored</u>: The Director of Environmental Services (DES), or his designee, will inspect all offices, med rooms, nourishment rooms and resident rooms on a weekly basis for at least 60 days where refrigerators are in use to</p>	

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			ensure that no new surge protectors have been introduced. If no incidents of non-compliance are found, those inspections will be conducted on a monthly basis for at least an additional 6 months. The DES will report findings from the inspections to the QA Committee which meets quarterly. Any non-compliance found will result in additional corrections and extended monitoring to be determined by the QA Committee.		