

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155496	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/07/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 333 W MISHAWAKA RD ELKHART, IN 46517
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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
K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/07/13</p> <p>Facility Number: 000523 Provider Number: 155496 AIM Number: 100266930</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist and Libby Fruth, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Kindred Nursing and Rehabilitation Valley View 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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the</p>	K010000	<p>This Plan of Correction is thecenter's credible allegation ofcompliancePreparation and/or execution ofthis plan of correction does notconstitute admission oragreement by the provider of thetruth of the facts alleged orconclusions set forth in thestatement of deficiencies. Theplan of correction is preparedand/or executed solely because itis required by the provisions offederal and state law.</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>corridors. Battery operated smoke detectors are provided in all 73 resident rooms. The facility has a capacity of 126 and had a census of 106 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has a detached garage providing storage of maintenance equipment and a shed containing storage of wheel chairs and walkers which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/14/13.</p> <p>The facility was not found in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 100 doors protecting corridor openings did not have an impediment to the closing of the door. This deficient practice could affect approximately ten residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 11/07/13 during a tour from 12:30 p.m. to 2:50 p.m. with the Executive Director and Maintenance Director, the door to resident room 108 was blocked open by a wedge pushed under the door. Based on interview during the time of observation with the Executive Director and Maintenance Director, it was acknowledged the door</p>	K010018	Obstructions have been removed from doorway 108 per requirement. Staff will monitor this area to prevent reoccurrence. All other resident room doors have been inspected for impediment to the closing of the door, and none have been found. The Maintenance Director or designee will make rounds throughout the facility on a weekly basis and will monitor to ensure there are no impediments to the closing of the doors. These weekly audits are to be reviewed by the Executive Director to ensure proper compliance. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.	12/07/2013			

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	was propped open. 3.1-19(b)			

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure openings through 1 of 7 smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect approximately 10 of 106 residents, staff and/or visitors using the 100 hall if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observation on 11/07/13 during a tour from 12:30 p.m. to 2:50 p.m. with</p>	K010025	The 100 hall smoke barrier penetration has been sealed using appropriate fire rated material. All smoke barrier walls have been inspected/sealed to ensure effective smoke resistance throughout the facility. The Maintenance Director will inspect all smoke/fire barrier walls quarterly for proper firestop to any penetrated area. These inspections will be documented in the facility Preventative Maintenance Log. These audits are to be reviewed quarterly by the Executive Director to ensure proper compliance. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.	12/07/2013			

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	<p>the Executive Director and Maintenance Director, the 100 hall smoke barrier had two penetrations through the smoke barrier wall above the ceiling tile that was not firestopped. One penetration was a one inch hole with a penetrating wire and and the other penetration was a two inch pipe sleeve with penetrating wires through the drywall smoke barrier with a one inch gap which was not firestopped. The aforementioned holes in the smoke barrier were acknowledged by the Maintenance Director at the times of observation.</p> <p>3.1-19(b)</p>			

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K010027 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 Based on observation and interview, the facility failed to ensure 1 of 7 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 two of seven smoke compartments.</p> <p>Finding include:</p> <p>Based on observation on 11/07/13 during a tour from 12:30 p.m. to 2:50 p.m. with the Executive Director and Maintenance Director, doors for the smoke barrier near the south dining room and the beauty shop did not operate properly preventing the doors from closing completely leaving</p>	K010027	The smoke barrier door near the South Dining Room and the smoke barrier door near the Beauty Shop have been repaired and are now closing and latching properly. All other smoke barrier doors have been inspected and are closing and latching properly. The Maintenance Director will inspect all smoke barrier doors for proper operation monthly. These monthly audits are to be reviewed by the Executive Director to ensure proper compliance. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.	12/07/2013	

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	a half inch gap. This was confirmed by the Maintenance Director at the time of observation. 3.1-19(b)			

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K010038 SS=B	<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 15 exit doors with a delayed egress lock initiated an audible signal in the vicinity of the door when activated.</p> <p>LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided:</p> <p>(a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6.</p> <p>(b) The doors unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon</p>	K010038	The exit door near the North Laundry has been repaired and is now generating an audible signal as required. All other exit doors have been inspected for proper operation and are generating an audible signal as required. The Maintenance Director will inspect exit access doors weekly and document any issues and make corrections as needed. These weekly audits are to be reviewed by the Executive Director to ensure proper compliance. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.	12/07/2013			

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	<p>application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS".</p> <p>This deficient practice could affect any resident, staff or visitor who use the exit near the north laundry room.</p> <p>Findings include:</p> <p>Based on observation on 11/07/13 during a tour from 12:30 p.m. to 2:50 p.m. with the Executive Director and Maintenance Director, the exit door near the north laundry was provided with a fifteen second delay with proper signage but when force was applied to the releasing</p>			

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	<p>device on the door, the door released after 15 seconds but an audible signal was not generated. Based on interview at the time of observation, the Executive Director acknowledged a audible signal was not generated.</p> <p>3.1-19(b)</p>			

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K010048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to include staff response to battery operated smoke detectors and the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice affects any resident, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire safety plan and policy and procedures regarding staff response to battery operated smoke detectors and fire extinguisher maintenance with the Executive Director during record review from 9:45 a.m. to 11:30 a.m. on 11/07/13,</p>	K010048	The Emergency Response plan has been updated to address staff response to battery operated smoke detectors, the use of fire extinguishers and kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using the K-class fire extinguisher. The Emergency Response Plan has been reviewed and will be updated as needed by the Safety Committee and Executive Director. The Emergency Response Plan will continue to be reviewed quarterly and updated as needed by the Safety Committee and the Executive Director. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.	12/07/2013			

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	<p>the fire safety plan did not address staff response to battery operated smoke detectors located in the resident rooms; the use of the fire extinguishers and the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Executive Director acknowledged the written fire safety plan for the facility did not address staff response to battery operated smoke detectors, the use of fire extinguishers and kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using the K-class fire extinguisher.</p> <p>3.1-19(b)</p>			

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K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>1. Based on interview and record review, the facility failed to conduct quarterly fire drills on each shift for 1 of 4 quarters. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Fire/Disaster Drill Reports" with the Executive Director from 9:30 a.m. to 11:30 a.m. on 11/07/13, fire drills were not documented for the first, second and third shifts of the fourth quarter of 2012. Based on interview at the time of record review, the Executive Director acknowledged documentation of fire drills for all three shifts for the fourth quarter of 2012 was not available for review to verify these drills were conducted.</p> <p>3.1-19(b)</p>	K010050	<p>Fire Drill records for the 4th quarter of 2012 could not be located. The Maintenance Director has been in-serviced on correct procedures for conducting fire drills. The fire drill records will be reviewed monthly by the Executive Director to ensure future compliance. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.</p>	12/07/2013			

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	<p>3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to conduct fire drills at unexpected times in 7 of 9 fire drills. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Fire/Disaster Drill Reports" with the Executive Director from 9:30 a.m. to 11:30 a.m. on 11/07/13, the following was noted:</p> <p>a. Three of three first shift fire drills were conducted on 03/27/13 at 11:15 a.m.; 06/25/13 at 11:30 a.m.; and 08/30/13.</p> <p>b. Two of three second shift fire drills were conducted on 04/30/13 at 3:00 p.m. and 09/27/13 at 3:45 p.m.</p> <p>c. Two of three third shift fire drills were conducted on 05/28/13 at 4:30 a.m. and 07/25/13 at 5:00 a.m. Based on interview at the time of review, the Executive Director acknowledged the fire drills were often held near the end of the month and at nonvaried times.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>3. Based on record review and interview, the facility failed to activate the fire alarm</p>						

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	<p>system for fire drills conducted between 6:00 a.m. and 9:00 p.m. on the second shift for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire/Disaster Drill Reports" with the Executive Director from 9:30 a.m. to 11:30 a.m. on 11/07/13, documentation for the second shift fire drill conducted at 3:45 p.m. on 09/27/13 stated the drill was a silent drill. Based on interview at the time of record review, the Executive Director acknowledged the 09/27/13, second shift fire drill conducted before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal.</p> <p>3.1-19(b) 3.1-51(c)</p>			

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K010064 SS=C	<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 inspect 15 of 15 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing it being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect all residents as well as staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation on 11/07/13 during a tour from 12:30 p.m. to 2:50 p.m. with the Executive Director and Maintenance Director, the monthly inspection tag on the fire extinguishers located throughout the facility lacked documentation of a</p>	K010064	All portable fire extinguishers have been inspected and/or replaced. The Maintenance Director has been trained for the inspection all portable fire extinguishers monthly. The monthly inspections will be documented in the Preventive Maintenance Log and on the inspection ticket attached to the extinguisher itself. The fire extinguisher inspection records will be reviewed monthly by the Executive Director to ensure future compliance. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.	12/07/2013			

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	<p>monthly inspection for the month of October of 2013. Based on interview during the times of observation, this was acknowledged by the Executive Director.</p> <p>3.1-19(b)</p>			

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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on interview, 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> <ul style="list-style-type: none"> a) Liquid Petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas <p>Exception: For Level 1 installations in locations where the probability of interruption of offsite 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 system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all residents, staff and visitors.</p>	K010144	The letter from the natural gas provider indicating the natural gas is from a reliable source has been located and has been added to the facility Life Safety Book. The emergency generator has been inspected by a licensed contractor and found to be in good working order. The Maintenance Director has been trained on conducting monthly testing of the emergency generator, including power transfer during monthly load tests and documentation of same as routine preventive maintenance. The Executive Director will review weekly logs of generator testing to ensure scheduled generator tests are being conducted as required. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.	12/07/2013
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	<p>Findings include:</p> <p>Based on interview with the Executive Director and Maintenance Director at 10:00 a.m. on 11/07/13, the fuel source for the emergency generator was natural gas. Based on interview at the exit , the Executive Director confirmed the facility did not have a letter from their natural gas provider indicating the natural gas was from a reliable source.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 6 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available to the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p>						

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	<p>Findings include:</p> <p>Based on review of "Emergency Generator-Monthly Log Sheet" documentation with the Executive Director and Maintenance Director on 11/07/13 from 9:45 a.m. to 11:30 a.m., the transfer time was not documented for the months of February, March, April, May, September and October of 2013. Based on interview at the time of record review, the Executive Director acknowledged emergency power transfer time for the aforementioned monthly load tests was not documented.</p> <p>3.1-19(b)</p>			

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K010147 SS=B	<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 1 of 1 ground fault circuit interrupter (GFCI) receptacles in the therapy equipment storage room operated properly to protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subjected to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice was not in a resident area and would not directly affect residents but could affect staff.</p> <p>Findings include:</p> <p>Based on observation on 11/07/13 during a tour from 12:30 p.m. to 2:50 p.m. with the Executive Director and Maintenance Director, there was a GFCI electrical receptacle on the wall within two feet of</p>	K010147	The issue with the ground fault circuit interrupter (GFCI) receptacle in the Therapy Room has been repaired. All rooms have been inspected to ensure ground fault circuit interrupter (GFCI) receptacles are functioning properly. The Maintenance Director will conduct a biennial audit of ground fault circuit interrupter (GFCI) receptacles to ensure proper function. These biennial audits are to be reviewed by the Executive Director to ensure proper compliance. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.	12/07/2013

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	<p>the sink in the therapy equipment storage room. When tested with the test button on the receptacle, power was not interrupted. The Maintenance Director acknowledged the GFCI test button did not interrupt power at the receptacles in the therapy equipment storage room.</p> <p>3.1-19(b)</p>			

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K019999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(a) The facility must be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel, and the public.</p> <p>This State Rule has not been met as evidenced by: Based on record review, observation and interview, the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 73 of 73 resident sleeping rooms. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of facility records with the Executive Director from 9:45 a.m. to 11:30 a.m. on 11/07/13, an itemized listing of monthly battery operated smoke detector testing for each resident sleeping room location was not available for review. Based on observation on 11/07/13 during a tour from 12:30 p.m. to 2:50 p.m. with the Executive Director and</p>	K019999	<p>Room 105 now has a working battery operated smoke detector. All resident rooms have been inspected to ensure each resident room contains a battery operated smoke detector and each one is in good working order. The Maintenance Director will conduct a weekly audible inspection of battery operated smoke detectors in all resident rooms to ensure proper functioning, and monthly cleaning of battery operated smoke detectors per manufacturer's specifications. These audits are to be reviewed by the Executive Director to ensure proper compliance. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed.</p>	12/07/2013			

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	<p>Maintenance Director, battery operated smoke detectors were provided in all resident rooms except for room # 105 which had only the base plate for the smoke detector. Based on interview at the time of record review, the Executive Director acknowledged documentation of the periodic testing and cleaning for resident room battery operated smoke detectors was not available for review and also acknowledged the missing smoke detector in resident room #105.</p> <p>3.1-19(a)</p>			