

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2016
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NAME OF PROVIDER OR SUPPLIER CREEKSIDE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
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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: 05/31/16</p> <p>Facility Number: 012329 Provider Number: 155784 AIM Number: 201002500</p> <p>At this Life Safety Code survey, Michiana Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies.</p> <p>This one story facility built in 2010 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 spaces open to the corridors with hard wired smoke detectors in all the resident sleeping rooms. The facility has a capacity of 100 and had a census of 90 at</p>	K 0000	<p>This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Life Safety Codeinspection report. Creekside Village requests consideration for a desk review of this plan of correction in lieu of post survey revisit.</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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K 0018 SS=D Bldg. 01	<p>the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for an eight by ten foot wood shed used for storage.</p> <p>Quality Review completed on 06/02/16 - DA</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 2 of 80 resident room corridor doors closed and latched into the door frame. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation and interview on 05/31/16 at 10:55 a.m. then again at</p>	K 0018	<p>K018</p> <p>1.This deficient practice has the potential to affect the occupants in the two patient rooms identified. To ensure this deficient practice does not occur again, Maintenance Supervisor and or designee will check all doors to ensure doors latch appropriately. Any doors that found to not be in compliance will be corrected immediately. A continuous quality improvement tool will be completed weekly, monthly thereafter for 6</p>	06/30/2016

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K 0025 SS=F Bldg. 01	<p>12:00 p.m., the Director of Nursing acknowledged the corridor door to resident room 309 failed to latch into the frame when tested. Then again, the corridor door to resident room 105 failed to latch into the frame when tested.</p> <p>3.1-19(b)</p> <p>2. Based on observation, the facility failed to ensure 1 of 1 Janitor's room door was capable of resisting smoke. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Director of Nursing on 05/31/16 at 10:43 a.m., the corridor door to the Janitor's room was not smoke resistant due to a half inch and a quarter inch hole drilled through. Based on interview at the time of observation, the Director of Nursing acknowledged the aforementioned condition.</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,</p>		<p>months and then quarterly thereafter. Corrective actions will be completed by June 30, 2016.</p> <p>2. This deficient practice has the potential to affect staff only and is an isolated incident. Identified door will be corrected by Maintenance Supervisor or designee by replacing proper hardware and door handle and keypad. A continuous quality improvement tool will be completed weekly, monthly thereafter for 6 months and then quarterly thereafter. Corrective actions will be completed by June 30, 2016.</p>	

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	<p>18.3.7.3, 18.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 1 ceiling and 3 of 3 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 18.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so 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 all occupants.</p> <p>Findings include:</p> <p>Based on observations with the Director of Nursing on 05/31/16 between 10:32 a.m. and 1:49 p.m., the following unsealed penetrations were discovered:</p> <ul style="list-style-type: none"> a) a half inch gap around wires in the ceiling in the Central Supply Electrical room b) one tile missing in the corridor outside the Main Central Supply c) a three quarter inch gap on top of 	K 0025	<p>K025</p> <p>This deficient practice has the potential to affect all occupants. All issues identified will be corrected by Maintenance Supervisor and/or designee up to Life Safety Code Standards. To ensure compliance, Maintenance Supervisor has been orientated to appropriately manage all vendors/contractors to ensure that any penetrations in fire barriers are sealed to life safety standards. Corrective Actions will be completed by June 30, 2016.</p>	06/30/2016

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K 0029 SS=E Bldg. 01	<p>conduit above the drop ceiling in the smoke barrier near resident room 101.</p> <p>d) a one inch and two separate quarter inch penetrations in the 300 Hall attic smoke barrier.</p> <p>e) a one inch penetrations around a cable in the smoke barrier near resident room 110.</p> <p>Based on interview at the time of each observation, the Director of Nursing acknowledged each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1.</p> <p>1. Based on observation and interview, the facility failed to ensure corridor doors to 1 of 1 fuel fired 400 Hall Mechanical room, a hazardous area, would positively latch into the frame. This deficient practice could affect up to 48 residents.</p> <p>Findings include:</p>	K 0029	<p>K029</p> <p>1. This deficient practice has the potential to affect up to 48 residents. Maintenance Supervisor identified root cause of door not latching and issue was fixed on June 11, 2016.</p> <p>To ensure this deficient practice does not occur again, Maintenance Supervisor and or designee will check all doors to</p>	06/30/2016

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	<p>Based on observation with the Director of Nursing on 05/31/16 at 10:57 a.m., the 400 Hall Mechanical room contained fuel fired appliances. The corridor door failed to latch into the frame when tested. Based on interview at the time of observation, the Director of Nursing acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure corridor doors to 1 of 1 fuel fired Kitchen room, a hazardous area, would positively latch into the frame. This deficient practice was not in a resident care but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Director of Nursing on 05/31/16 at 10:18 a.m. then again at 10:25 a.m., the Kitchen contained fuel fired appliances. One of the two kitchen doors that opened to the Dining Room failed to positively latch into the frame when tested. Then again, the one set of Kitchen double doors left a three eights inch gap in between the doors when closed. Also, one of the two double doors contained manual latching hardware. Based on interview at the time of each observation, the Director of</p>		<p>ensured doors latch appropriately. Any doors that found to not be in compliance will be corrected immediately.</p> <p>A continuous quality improvement tool will be completed weekly, monthly thereafter for 6 months and then quarterly thereafter. Corrective actions will be completed by June 30, 2016.</p> <p>2. This deficient practice has the potential to affect facility staff in the identified area. Kitchen door to dining room was fixed on June 14, 2016. One set of kitchen doors will re-adjusted to eliminate the gap and manual latching hardware will be removed and vendor will install appropriate hardware. Corrective Actions will be completed by June 30, 2016. K029</p> <p>3. This deficient practice had the potential to affect 2 patients in the area at the time. Popcorn popper will be moved to the Activity Room where there is a smoke barrier door. Staff will be in service on where popcorn popper can be used on 6/21/2016. Corrective Actions will be completed by June 30, 2016.</p>		

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K 0048 SS=F Bldg. 01	<p>Nursing acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 2 hazardous cooking areas was separated from the corridor by smoke resistive partitions or doors. This deficient practice could affect at least 2 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Nursing on 05/31/16 at 10:11 a.m., a mobile popcorn popper was in the Parlor room. The Parlor room does not have a full smoke resistive partition from the corridor because the room contains a door frame without a door. Based on interview at the time of observation, the Director of Nursing acknowledged the aforementioned condition and confirmed that popcorn was popped in the Parlor room.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1</p> <p>Based on record review and interview,</p>	K 0048	K048	06/30/2016

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	<p>the facility failed to provide a written plan that addressed all components of the in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that 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 could affect all occupants.</p> <p>Findings include:</p> <p>Based on a record review with the Director of Nursing on 05/31/16 between 10:00 a.m. and 2:15 p.m., the facility had a written fire policy that horizontal evacuation would be performed by crossing a fire barrier. However, there were corridor doors that were not complete smoke or fire barriers which could cause staff to evacuate residents to a different part of the same smoke compartment and not to an adjacent compartment in the event of a fire. Based on observation, the 400 Hall and 200</p>		<p>This deficient practice has the potential to affect all occupants in facility.</p> <p>All staff will be inserviced on 6/21/16 on location of fire doors whereto appropriately evacuate residents in event of fire.</p> <p>To ensure compliance, staff will be monitored during fire drills for appropriate evacuation procedures and documented on fire drill form by CEC.</p> <p>Corrective Actions will be completed by June 30, 2016.</p>	

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K 0050 SS=F Bldg. 01	<p>Hall barriers did not extend into the attic. Based on interview at the time of each observation, the Director of Nursing acknowledged the 400 Hall and 200 Hall set of doors was not part of a complete smoke or fire barrier.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 3 of the last 4 calendar quarters. This deficient practice could affect all staff and residents.</p> <p>Findings include: Based on record review of the "Monthly Fire Drill Report" forms with the Director of Nursing on 05/31/16 at 10:18 a.m., the documentation for a first shift fire drill for the first quarter of 2016 was</p>	K 0050	<p>K050 This deficient practice has the potential to affect all staff and residents. Missing documentation was identified and Facility has conducted fire drills per policy. Maintenance Director and Executive Director have been educated on facility fire drill schedule to ensure drills will be carried out in accordance to policy. To ensure compliance Executive Director and/or designee will review the fire drill forms for compliance.</p>	06/30/2016

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K 0051 SS=E Bldg. 01	<p>not available for review. Additionally, the documentation for a second shift fire drill for the second quarter of 2015 was not available for review. Additionally, the documentation for a third shift fire drill for the second and fourth quarter of 2015 was not available for review. Based on interview at the time of record review, the Director of Nursing acknowledged the lack of documentation.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates</p>		All corrective action will be completed by June30, 2016	

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	<p>required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure smoke detectors in 1 of 1 Dietary Manager's office, 1 of 1 Laundry, and 1 of 1 Sun Room was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect staff and at least 2 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Nursing on 05/31/16 between 10:21 a.m. and 12:04 p.m., the following was discovered:</p> <p>a) 1 of 1 smoke detector twenty four inches away from an HVAC vent in the Dietary Manager's office</p> <p>b) 1 of 2 smoke detectors twenty four inches away from an HVAC vent in the Laundry room.</p> <p>c) 1 of 2 smoke detectors eighteen inches away from ceiling fan blades in the Sun room.</p> <p>Based on interview at the time of each observation, the Director of Nursing acknowledged the aforementioned condition and provided the</p>	K 0051	<p>K051</p> <p>This deficient practice has the potential to affect all staff and 2 residents in the area. Smoke detectors identified as areas of concern will be corrected by Maintenance Director and or designee where possible and contractor for all other areas. All smoke detectors will be audited by Vendor to ensure they are placed appropriately according to Life Safety Code Standards. Any further identified issues will be corrected immediately. All corrective actions will be corrected by June 30, 2016.</p>	06/30/2016

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K 0052 SS=F Bldg. 01	<p>measurements.</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 applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, Based on record review and interview, the facility failed to ensure 1 of 1 facility's smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be</p>	K 0052	<p>K052 This deficient practice has potential to affect all staff, residents, and guests of facility. New vendor was brought in January of 2016 to replace previous vendor that serviced sprinkler system, smoke detectors and sensitivity tests. Sensitivity test will be completed and facility will be in full compliance by date certain. All corrective actions will be corrected by June 30, 2016</p>	06/30/2016

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	<p>maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all staff, resident, and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview on 05/31/16 between 9:30 a.m. and 10:34 a.m., the Director of Nursing acknowledged that no sensitivity documentation was available for review.</p>			

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K 0062 SS=F Bldg. 01	<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 record review and interview, the facility failed to ensure the sprinkler system components was inspected quarterly for 2 of 4 calendar quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Director of Nursing on 05/31/16 from 9:30 a.m. to</p>	K 0062	<p>K062</p> <p>This deficient practice has the potential to affect all staff, residents and guest of facility. Facility received first quarter documentation after Life Safety Code Survey. Approved facility vendor will complete quarterly sensitivity testing per regulation. To ensure compliance, the Maintenance Director and or designee will complete the Preventative maintenance tool to ensure work is complete and documentation is available for facility review. All corrective actions will be corrected by June 30, 2016.</p>	06/30/2016

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K 0066 SS=D Bldg. 01	<p>10:34 a.m., there was no second quarter of 2015 sprinkler system inspection report and no first quarter of 2016 sprinkler system inspection report available for review. Based on interview at the time of record review, the Director of Nursing acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99) (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 8-3.1.11.3 (NFPA 99) (2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied</p>			

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K 0076 SS=D Bldg. 01	<p>shall be readily available to all areas where smoking is permitted.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was not permitted was maintained. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations with the Director of Nursing on 05/31/16 at 10:38 a.m., there were at least 60 cigarette butts on the ground near Employee Parking entrance. Based on interview at the time of observation, the Director of Nursing acknowledged the aforementioned condition and confirmed that the facility has a smoke-free policy.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4</p>	K 0066	<p>K066 This deficient practice has the potential to affect staff only. Cigarette butts identified on grounds were cleaned up immediately. Facility staff will be re-inserve staff on 6/21/16 about non-smokingpolicy. Maintenance and or designee will complete daily rounds on facilitygrounds. Allcorrective actions will be corrected by June 30, 2016.</p>	06/30/2016

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	<p>Based on observation and interview, the facility failed to ensure 2 of 2 cylinders in the Maintenance office of nonflammable gases such as carbon dioxide were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Director of Nursing on 05/31/16 at 10:45 a.m., the Maintenance office had two carbon dioxide cylinders that was freestanding on the floor. Based on interview at the time of observation, the Director of Nursing acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0076	<p>K076</p> <p>This deficient practice has the potential to affect staff only. CO2 tanks will be properly secured and stored per Life Safety Coderegulations. Allcorrective actions will be corrected by June 30, 2016.</p>	06/30/2016
K 0144 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Based on record review and interview,</p>	K 0144	<p>K144</p> <p>This deficient practice has the</p>	06/30/2016

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	<p>the facility failed to ensure a written record of weekly inspections of the starting batteries for the generator was maintained for 12 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. 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 by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview and review of generator documentation on 05/31/16 at 10:20 a.m., the Director of Nursing acknowledged that twelve of fifty two weeks of visual inspections of the generator were not performed.</p>		<p>potential could affect all residents,staff and visitors. Appropriate documentation was not complete by previous maintenancedirector. New maintenance director was hired on and appropriately oriented tofacility policy on weekly generator tests. Tests will be done weekly and documented on "Emergency Generator WeeklyExercise/Monthly Load Test Log". Allcorrective actions will be completed by June 30, 2016</p>	

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K 0147 SS=E Bldg. 01	<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>Based on observation and interview, the facility failed to ensure 6 of 6 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 48 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Nursing on 05/31/16 between 10:04 a.m. to 11:45 a.m. the following was discovered:</p> <p>a) a surge protector was powering a microwave and a refrigerator in the Social Service office</p> <p>b) a surge protector was powering another surge protector powering television equipment in the Central Supply room.</p> <p>c) a surge protector was powering a refrigerator in the 400 Hall Unit</p>	K 0147	<p>K147</p> <p>This deficient practice has the potential to affect up to 48 residents.</p> <p>Two office surge protectors were removed immediately and appliances were plugged directly into outlet.</p> <p>Telephone room and Central supply room will have outlets installed by contractor to eliminate the need for surge protectors.</p> <p>All corrective actions will be completed by June 30, 2016.</p>	06/30/2016
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	<p>Manager's office</p> <p>d) a surge protector was powering another surge protector powering telephone equipment in the 200 Hall Telephone room.</p> <p>Based on interview at the time of observation, the Director of Nursing acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>				