

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155684	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/09/2014
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NAME OF PROVIDER OR SUPPLIER  SOUTHFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6450 MIAMI CIR SOUTH BEND, IN 46614
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/09/14</p> <p>Facility Number: 002662 Provider Number: 155684 AIM Number: 200315930</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist, Libby Fruth, Life Safety Code Specialist</p> <p>At this Life Safety Code Survey, Southfield Village 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 is adjacent to an assisted living unit and separated by a two hour rated fire wall.</p>	K010000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. The submission of this Plan of Correction is not an admission that a deficiency exists or that a deficiency was cited correctly. This Plan of Correction is being submitted to meet the requirements established by State and Federal law.	

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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K010011 SS=F	<p>The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and hard wired smoke detectors in the resident sleeping rooms. The facility has a capacity of 60 and had a census of 59 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/16/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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 are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 Based on observation and interview, the</p>	K010011	The penetration was immediately	02/08/2014
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	<p>facility failed to provide a two hour fire rated separation in 1 of 1 two hour fire rated walls between the skilled nursing unit and the assisted living occupancy with firestopped fire barrier penetrations. LSC Section 8.2.3.2.4.2 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 fire barrier shall be filled with a material capable of maintaining the fire resistance of the fire barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect all of the 49 residents as well as an undetermined number of staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Director from 1:30 p.m. to 3:15 p.m. on 01/09/14, the fire barrier wall above the ceiling tiles at the occupancy separation had a one inch hole with a cable running through it which was not fire stopped. Based on interview at the time of observation, the Environmental Services Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>sealed using a fire resistive chalk while the surveyor was still present in the facility. All other fire walls have been inspected for openings, none were found. Systemically, following any work that is done by staff or a contractor that could compromise the structural integrity of a fire wall, the fire wall will immediately be inspected and repaired if necessary by the facility Maintenance staff. The Physical Plant and Safety Committee, a quality assurance group, will monitor that new penetrations have not been made after each activity that could compromise the firewall. The Director of Environmental Services is responsible to carry out the plan of correction. Failure to carry out the plan of correction may result in disciplinary action up to and including termination.</p>				

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K010018 SS=F	<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 13 of 13 closets with double corridor doors closed and latched automatically into the door frame. This deficient practice could affect all of the 49 residents as well as an undetermined number of staff and visitors.</p> <p>Findings includes:  Based on observation with the</p>	K010018	<p>Bids will be received by February 8, 2014, to purchase self latching devices for the doors cited. Work will begin to install the devices by March 8, 2014 and be completed by March 15, 2014. Systemically, all other doors in the facility have been evaluated and found to be in compliance. Monthly during each fire drill, all doors will be inspected to assure they full close and latch properly. In the future, if a door ever needs to be replaced, only doors that comply with this requirement will be</p>	02/08/2014

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K010029 SS=E	<p>Environmental Services Director from 1:30 p.m. to 3:15 p.m. on 01/09/14, the clean linen, storage, housekeeping, mechanical and pantry closets on the 100, 200 and 300 halls each had a set of double corridor doors. On each set of doors, one door was equipped with a manual latching device that would latch into the door frame and the remaining door was designed to latch into the stationary door. Each door could not latch automatically, and independent of the other door, into the door frame. This was acknowledged by the Environmental Services Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p>		<p>purchased. The Physical Plant and Safety Committee, a quality assurance group, will monitor the results of the fire drills and subsequent inspection of the doors latching correctly at a minimum of quarterly. The Director of Environmental Services is responsible to carry out the plan of correction. Failure to carry out the plan of correction may result in disciplinary action, up to and including termination.</p>	

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K010046 SS=C	<p>Based on observation and interview, the facility failed to ensure 1 of 5 doors serving hazardous areas such as a kitchen closed and latched to prevent the passage of smoke. This deficient practice could affect 20 residents using the dining room as well as an undetermined number of staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Director from 1:30 p.m. to 3:15 p.m. on 01/09/14, the double set of doors from the kitchen into the dining room lacked a door closer on one of the doors. Based on interview during the time of observation, the Environmental Services Director acknowledged the aforementioned hazardous area door lacked a self closer to ensure the doors closed and latched into the door frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the</p>	K010029	<p>A door closure has been installed on the current door. A bid for a new set of doors will be received by February 8, 2014. The work to install the new doors, that includes a self closing device will begin no later than March 8th and completed by March 15, 2014. Systemically, all other doors in the facility have been evaluated and found to be in compliance. Monthly during each fire drill, all doors will be inspected to assure they full close and latch properly. In the future, if a door ever needs to be replaced, only doors that comply with this requirement will be purchased. The Physical Plant and Safety Committee, a quality assurance group, will monitor the results of the fire drills and subsequent inspection of the doors latching correctly at a minimum of quarterly. The Director of Environmental Services is responsible to carry out the plan of correction. Failure to carry out the plan of correction may result in disciplinary action, up to and including termination.</p>	02/08/2014			
		K010046	<p>The testing of the emergency generator battery back up light</p>	02/08/2014			

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	<p>facility failed to ensure 1 of 1 emergency generator battery backup lights was tested monthly for 30 seconds and tested annually for 90 minutes to ensure the light would provide lighting during periods of power outages to protect residents. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Director from 1:30 p.m. to 3:15 p.m. on 01/09/14 during the tour of the facility, the emergency generator location was provided with a battery operated emergency light which functioned when tested. Based on an interview with the</p>		<p>has now been documented. All other emergency lighting systems have been tested and documented. Systemically, the Emergency Generator Monthly Inspection Log has been updated to include the testing of the battery back up lighting system. The Physical Plant and Safety Committee, a quality assurance group, will review the completion of the Emergency Generator Monthly Inspection Log at a minimum of quarterly. The Director of Environmental Service is responsible to carry out the plan of correction. Failure to carry out the plan of correction may result in disciplinary action, up to and including termination.</p>		

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K010050 SS=F	<p>Environmental Services Director during the time of record review, the facility had no documentation of monthly or annual emergency generator battery backup light testing.</p> <p>3.1-19(b)</p> <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 2 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 Drill Reports" with the Environmental Services Director from 11:15 a.m. to 1:30 p.m. on 01/09/14, fire drills were not</p>	K010050	<p>Fire drills will be conducted on each shift, quarterly at random times. Systemically, a new fire drill schedule has been completed for calendar year 2014. The schedule assure that drills are conducted quarterly and at random on each shift. The Physical Plant and Safety Committee, a quality assurance group, will monitor that fire drills are conducted in accordance with the schedule. The Director of Environmental Services will be responsible to carry out the plan of correction. Failure to carry out</p>	02/08/2014

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	<p>documented for the second shift of the third quarter of 2013 or the third shift of the second quarter of 2013. Based on interview at the time of record review, the Environmental Services Director acknowledged the fire drills were not documented and there was no other documentation available for review to verify these drills were conducted.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to conduct fire drills at unexpected times in 9 of 12 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 Drill Reports" with the Environmental Services Director from 11:15 a.m. to 1:30 p.m. on 01/09/14, the following was noted:</p> <p>a. Three of five first shift fire drills were conducted on 3/29/13 at 2:00 p.m., 05/16/13 at 2:18 p.m. and 11/27/13 at 2:12 p.m.</p> <p>b. Three of three second shift fire drills were conducted on 01/10/13 at 3:30 p.m., 06/19/13 at 3:15 p.m. and 12/14/13 at 2:30 p.m.</p>		the plan of correction may result in disciplinary action up to, and including termination.				

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K010051 SS=B	<p>c. Three of four third shift fire drills were conducted on 02/27/13 at 4:00 a.m., 08/22/13 at 5:15 a.m. and 09/16/13 at 4:45 a.m.</p> <p>Based on interview at the time of record review, the Environmental Services Director acknowledged the fire drills were not held randomly.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoke detectors located in the 100 hall sitting</p>	K010051	The smoke detector, originally installed at the time of construction, has been moved away from the air return vent. All	02/08/2014

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K010062 SS=C	<p>area and connected to the fire alarm system was properly separated from an air supply or return vent. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect at least 10 residents as well as staff and visitors using the 100 hall sitting area.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Director from 1:30 p.m. to 3:15 p.m. on 01/09/14, a corridor smoke detector located in the 100 hall sitting area was 12 inches from an air return vent. Based on interview at the time of observation, the Environmental Services Director acknowledged the distance between the vent and agreed the air flow could interfere with smoke detector function.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p>		<p>other smoker detectors have been inspected to assure they are located away from air supply and return sources. None were found to be close to a supply or return source. Systemically, no new smoke will be installed or existing detectors moved with out the approval of the Physical Plant and Safety Committee. The Director of Environmental Services is responsible to carry out the plan of correction. Failure to carry out the plan of correction may result in disciplinary action up to, and including termination.</p>				

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	<p>Based on observation, record review and interview; the facility failed to ensure sprinklers for 1 of 1 sprinkler systems were kept free from the accumulation of dust. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested 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 all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Director from 1:30 p.m. to 3:15 p.m. on 01/09/14, five of seven sprinklers in the Garden Dining room were covered with dust and sprinklers on the 100, 200 and 300 hall near the return air vents were covered with dust. Based on review of a sprinkler inspection report dated 05/28/13 during record review from 11:15 a.m. to 1:30 p.m., the facility was advised of sprinkler heads with lint from duct diffusers. Based on interview at the time of the observations, the Environmental Services Director</p>	K010062	<p>The automatic sprinkler heads in the Garden Dining Room, in the 100, 200 and 300 Hallways have been cleaned of dust.</p> <p>All other automatic sprinkler heads in the facility have been inspected and cleaned if necessary.</p> <p>Systemically, the automatic sprinkler heads have been added to the quarterly preventative maintenance schedule for inspection and cleaning when necessary. The Physical Plant and Safety Committee, a quality assurance group, will monitor the completion of this task at least quarterly.</p> <p>The Director of Environmental Services is responsible to carry out the plan of correction. Failure to carry out the plan of correction may result in disciplinary action up to, and including termination.</p>	02/08/2014			

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K010067 SS=F	<p>acknowledged many of the sprinklers had dust on the deflector or fusible link.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 6 of 6 fire dampers throughout the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all 49 residents, staff and visitors.</p>	K010067	The fire dampers mentioned have been inspected and maintained in accordance with Life Safety Code requirements. All other fire dampers not mentioned have been inspected and are being maintained in accordance with Life Safety Code requirements. Systemically, the all fire dampers will be inspected and dated. The dampers will be added to the annual preventative maintenance schedule. The Physical Plant and Safety Committee, a quality assurance group, will monitor the completion of the task annually. The Director of Environmental Services is responsible to carry out the plan of correction. Failure to carry out the plan of correction may result in disciplinary action up to, and including termination.	02/08/2014	

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K010069 SS=A	<p>Findings include:</p> <p>Based on observation with the Environmental Services Director from 1:30 p.m. to 3:15 p.m. on 01/09/14, the facility has two fire dampers located in each of the HVAC mechanical closets located on the 100, 200 and 300 halls. Based on interview during the time of observation, the Environmental Services Director acknowledged there was no documentation regarding fire damper inspection and service within the past four years.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires</p>	K010069	The kitchen exhaust system has been cleaned. There are no other hoods in the facility that this could affect. Systemically, the schedule for cleaning the kitchen exhaust hood has been revised. The Physical Plant and Safety Committee, a quality assurance group will monitor the schedule quarterly to assure that it is followed and the work completed. The Director of Environmental Services is responsible to carry out the plan of correction. Failure to carry out	02/08/2014			

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	<p>systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect staff in the kitchen.</p> <p>Findings include:</p> <p>Based on record review with the Environmental Services Director from 11:15 a.m. to 1:30 p.m. on 01/09/14, documentation of the most recent semiannual kitchen exhaust system inspection was dated 08/08/13. The previous semiannual kitchen exhaust system was dated 01/12/13, a period greater than six months. Based on interview at the time of record review, the Environmental Services Director acknowledged a period greater than six months occurred between the most</p>		the plan of correction may result in disciplinary action up to, and including termination.				

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K010072 SS=E	<p>recent kitchen exhaust system inspection and the previous inspection.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of impediments to full instant use in the case of fire or other emergency for 1 of 5 exits. This deficient practice could affect at least 15 residents as well as staff and visitors in the Courtyard Dining room.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Director from 1:30 p.m. to 3:15 p.m. on 01/09/14, the exit path from the Courtyard Dining room to the courtyard gate was covered with a least a foot of snow. Based on</p>	K010072	The Courtyard Dining Room exit has been cleaned of snow to allow emergency egress following a state wide snow emergency. All other exits have been inspected and remain free of snow to allow emergency egress. Systemically, Maintenance will include the Courtyard Dining Room exit in their normal snow removal routine. In off hours, Nursing has been in-serviced to check the exits so they allow for emergency egress and contact Maintenance if the snow accumulation is greater than 4 inches. The Physical Plant and Safety Committee, a quality assurance group, will monitor for compliance with each snow fall. The Director of Environmental Services is responsible to carry out the plan of correction. Failure to carry out	02/08/2014			

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K010076 SS=B	<p>interview at the time of observation, the Environmental Services Director acknowledged the exit path from the Courtyard exit was snow covered.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards 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. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 electric switches in the oxygen storage room was located at least five feet above the floor. NFPA 99, 1999 Edition, Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage. This deficient practice could affect 10 residents, staff and visitors in the</p>	K010076	<p>the plan of correction may result in disciplinary action up to, and including termination.</p> <p>The light switch was raised to the appropriate height. There are no other oxygen storage rooms that could be affected by this practice. Systemically, if a new oxygen room were to be utilized or created, it will be in compliance with this requirement. The Physical Plant and Safety Committee, a quality assurance group will verify the light switch being raised to the appropriate height and monitor any future changes to this area. The Director of Environmental Service is responsible to carry out the plan of correction. Failure to carry out the plan of correction may result in disciplinary action</p>	02/08/2014			

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K010144 SS=F	<p>vicinity of the oxygen storage room.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Director from 1:30 p.m. to 3:15 p.m. on 01/09/14, there is a light switch on the wall in the oxygen storage room four feet (48 inches) above the floor. Based on interview with the Environmental Services Director, it was acknowledged the light switch was 48 inches above the floor in the oxygen storage room.</p> <p>3.1-19(b)</p> <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 record review and interview, the facility failed to ensure a written record of weekly inspections of the starting batteries for the generator was maintained for 50 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</p>	K010144	<p>up to, and including termination.</p> <p>Weekly and monthly documentation is being maintained on the emergency generator which includes that ability of the batteries to start the unit. There are no other areas affected by this practice. Systemically, a new Weekly Emergency Generator Checklist form is now being utilized. Maintenance staff have been in-serviced on how to</p>	02/08/2014			

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	<p>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 with the Environmental Services Director from 11:15 a.m. to 1:30 p.m. on 01/09/14, weekly generator inspections were not documented. The only generator service documentation was two semiannual generator inspections conducted by a generator contractor on 11/01/13 and 06/06/13 which included a load bank test.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to exercise</p>		<p>complete both the weekly and monthly forms. The Physical Plant and Safety Committee, a quality assurance group will monitor the logs for completion quarterly. The Director of Environmental Services is responsible to carry out the plan of correction. Failure to carry out the plan of correction may result in disciplinary action up to, and including termination.</p>		

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	<p>the generator for 10 of 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview and review of generator documentation with the</p>				

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K010147 SS=E	<p>Environmental Services Director from 11:15 a.m. to 1:30 p.m. on 01/09/14, monthly generator load tests were not documented. The only generator service documentation was two semiannual generator inspections conducted by a generator contractor on 11/01/13 and 06/06/13 which included a load bank test.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical junction boxes 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 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect at least 10 residents, visitor or staff using 200 hall.</p> <p>Findings include:</p>	K010147	A cover has been placed on the electrical junction box. A search has been conducted to try and locate all other electrical junction boxes. No others could be found that were missing a cover plate. Systemically, environmental audits will be conducted quarterly by the Physical Plant and Safety Committee, a quality assurance group. The environmental audits will include electrical devices. The Director of Environmental Services will be responsible to carry out the plan of correction. Failure to carry out the plan of correction may result in disciplinary action up to, and including termination.	02/08/2014

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K010154 SS=F	<p>Based on observation with the Environmental Services Director from 1:30 p.m. to 3:15 p.m. on 01/09/14, a four inch by four inch electrical junction box without a cover was above the ceiling tiles near the 200 hall smoke barrier. Based on interview at the time of the observations, the Environmental Services Director acknowledged the junction box lacked a cover.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1 in order to protect 49 of 49</p>	K010154	A copy of the facility's Fire Watch policy and Fire Watch Signature Sheet were found. All copies of the facility's Disaster Plans have been audited and updated to include the Fire Watch policy and any other current policies that may have been missing. Systemically, all staff have been in-serviced on the Fire	02/08/2014	

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	<p>residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview from 11:15 a.m. to 1:30 p.m. on 01/09/14, the Environmental Services Director acknowledged he knew what to do but was unable to produce a copy of the facility's fire watch policy and procedure.</p> <p>3.1-19(b)</p>		<p>Watch policy and procedure. This information will be included in the annual Fire and Safety in-services. The Director of Environmental Services is responsible to carry out the plan of correction. Failure to carry out the plan of correction may result in disciplinary action up to, and including termination.</p>				

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K010155 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to ensure its written fire watch policy addressed all procedures to be followed in this facility in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 in order to protect 49 of 49 residents. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview from 11:15 a.m. to 1:30 p.m. on 01/09/14, the Environmental Services Director acknowledged he knew what to do but was unable to produce a copy of the facility's fire watch policy and procedure.</p> <p>3.1-19(b)</p>	K010155	A copy of the facility's Fire Watch policy and Fire Watch Signature Sheet were found. All copies of the facility's Disaster Plans have been audited and updated to include the Fire Watch policy and any other current policies that may have been missing. Systemically, all staff have been in-serviced on the Fire Watch policy and procedure. This information will be included in the annual Fire and Safety in-services. The Director of Environmental Services is responsible to carry out the plan of correction. Failure to carry out the plan of correction may result in disciplinary action up to, and including termination.	02/08/2014			