

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155062	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/28/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-LAPORTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 I ST LA PORTE, IN 46350
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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: 04/28/14</p> <p>Facility Number: 000023 Provider Number: 155062 AIM Number: 100289400</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-LaPorte 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 with a partial basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke detectors in</p>	K010000		

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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K010014 SS=E	<p>the resident sleeping rooms. The facility has a capacity of 87 and had a census of 67 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a block building which is used for storage and the maintenance office.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/01/14.</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 Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure materials used as an interior finish in the corridor had a flame spread rating of Class A or Class B in order to protect 20 of 64 residents. LSC 101 10.2.3.2 states products required to be tested in accordance with</p>	K010014	<p>1. The wood-like material at the B-Wing nurses station will be treated for flame retardancy no later than May 28, 2014. Product (specs attached) has been ordered. The wooden lattice material is being permanently removed on 5.14.14. 2. All residents had the potential to be</p>	05/28/2014

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	<p>NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development.</p> <p>(a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire.</p> <p>(b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale.</p> <p>(c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect any resident on the 200 wing as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the</p>		<p>affected by the alleged negligent practice, but there were no known issues. 3. Wood or wood-like material will not be utilized in the building unless it can be certified as flame retardant. 4. The Executive Director will ensure that appropriate materials are purchased and utilized. 5. Completion date for all is no later than 5.28.14</p>		

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K010018 SS=E	<p>Maintenance Director during a tour of the facility on 04/28/14 from 11:30 a.m. to 2:30 p.m., the following was noted:</p> <p>a. The B wing nurses' station had a wood-like material used as siding with wood-like shingles used as an interior finish. Interview with the Maintenance Director at the time of observation revealed no documentation was immediately available to demonstrate the siding and shingles exhibited a flame spread classification of Class A or B.</p> <p>b. The main hall had water pipes along the ceiling that were boxed in with a lattice wood material. Interview with the Maintenance Director at the time of observation revealed no documentation was immediately available to demonstrate the lattice wood material exhibited a flame spread classification of Class A or B.</p> <p>3.1-19(b)</p> <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</p>						

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K010029 SS=D	<p>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 the doors to 1 of 1 rooms with double corridor doors closed and latched automatically into the door frame. This deficient practice could affect at least 20 residents in the main dining room as well as an undetermined number of staff and visitors.</p> <p>Findings includes:</p> <p>Based on observation with the Maintenance Director on 04/28/14 at 12:30 p.m., the main dining room had a set of double corridor doors. The set of doors was equipped with a manual flush bolt. The set of doors would not latch positively into the door frame. This was acknowledged by the Maintenance 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</p>	K010018	<ol style="list-style-type: none"> 1. A positive latching mechanism will be installed on the Main Dining Room double doors no later than 5.28.14. The needed part has been ordered by the Maintenance Director. 2. All residents had the potential to be affected by the alleged negligent practice but there were no identified issues. 3. The Maintenance Director will ensure that positive latching is in place, as required by code, during regular rounds and documented in the Building Engines program. 4. The Executive Director will monitor compliance through review of Building Engines. 5. Will be completed no later than 5.28.14. 	05/28/2014			

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	<p>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>Based on observation and interview, the facility failed to ensure 2 of 5 doors serving hazardous areas, such as areas with quantities of combustible materials exceeding 50 square feet, closed and latched to prevent the passage of smoke. This deficient practice could affect any resident using the beauty shop in the basement as well as staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Administrator on 04/28/14 from 2:00 p.m. to 2:15 p.m., the following was noted:</p> <p>a. The basement central supply room door lacked a door closer. This room exceeded 50 square feet and was used for the storage of a large quantity of combustible materials such as cardboard boxes and medical supplies wrapped in paper and plastic.</p> <p>b. The basement housekeeping storage room door lacked a door closer. This room exceeded 50 square feet and was used for the storage of a large quantity of</p>	K010029	<ol style="list-style-type: none"> 1. Closers were installed on both the central supply room and the housekeeping storage room doors by the Maintenance Director. Parts have been ordered and received. 2. All residents had the potential to be affected by the alleged negligent practice, but no issues have been noted. 3. Any remodeling or any door replacements will include the appropriate self-closing device. 4. The Maintenance Director and the Executive Director will review all construction and/or remodeling plans to ensure that the alleged deficient practice does not recur. 5. Work will be completed on or before 5.28.14 	05/28/2014

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K010046 SS=D	<p>combustible materials such as cardboard boxes. Based on interview at the time of observation, the Maintenance Director and Administrator acknowledged the doors to the aforementioned rooms did not self close and latch to prevent the passage of smoke.</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 facility failed to ensure 2 of 11 battery operated emergency lights in the facility were maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect any resident using the beauty shop</p>	K010046	<ol style="list-style-type: none"> The battery operated emergency lights were repaired by the Maintenance Director. All residents had the potential to be affected by the alleged negligent practice but no issues were noted. The Maintenance Director will check each battery operated emergency light on a monthly basis to ensure that they are functional, per code requirements. Results will be logged in the Building Engines system. The Executive Director will monitor compliance through review of the Building Engines system and random checks of the battery operated emergency lights. <p>5. 5.28.14</p>	05/28/2014			

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K010052 SS=F	<p>in the basement as well as staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Administrator on 04/28/14 from 2:00 p.m. to 2:30 p.m., the following was noted:</p> <p>a. The battery operated emergency light in the basement corridor outside the Housekeeping Manager's office did not function when tested.</p> <p>b. The battery operated emergency light in the Staff Development office in the basement did not function when tested.</p> <p>Based on interview at the time of observations, the Maintenance Director and Administrator acknowledged the aforementioned battery operated emergency lights did not function when tested.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to maintain 1 of 1 fire</p>	K010052	1. The process of replacing the 17 smoke detectors has begun. SafeCare has been contracted to	05/28/2014

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	<p>alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. 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 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' 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 		<p>complete the work (signed quote attached). The work will be completed no later than May 28, 2014 2. All residents had the potential to be affected by the alleged negligent practice, but no issues have been noted. 3. Sensitivity testing will be completed, as required by regulation, by SafeCare. Results of the testing will be reviewed by the Director of Maintenance; any units found not to be in compliance will be repaired/replaced per the recommendations of SafeCare. 4. The Executive Director will monitor compliance through review of the reports from SafeCare. 5. Completion date 5.28.14</p>				

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	<p>range</p> <p>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</p> <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 residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on review of the "Sensitivity Test & Inspection Report and Service Call Report dated 04/24/12 with the Maintenance Director on 04/28/14 from 10:150 a.m. to 11:30 a.m., there were 17 of 38 smoke detectors that failed the the sensitivity test. Based on interview during the time of record review, the Maintenance Director indicated there was no documentation of replacement or cleaning/recalibration of the failed smoke detectors.</p> <p>3.1-19(b)</p>				

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K010062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition. 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 Maintenance Director from 11:30 a.m. to 2:30 p.m. on 04/28/14, the following was noted:</p> <p>a. Eight of thirteen sprinkler heads in the therapy room, therapy bathroom and therapy pantry had paint on the deflector.</p> <p>b. Seven of seven sprinkler heads in the</p>	K010062	<ol style="list-style-type: none"> 1. Sprinkler heads cited in the report are in the process of being replaced by SafeCare. (see attached quote) Ceiling tiles were replaced. Cables that were zip tied to the sprinkler system have been relocated by the Director of Maintenance. 2. All residents had the potential to be affected by the alleged negligent practice but no issues were noted. 3. The Maintenance Director has been instructed, by the Executive Director and the Life Safety surveyor, to attach nothing to the sprinkler system, per code. 4. The Executive Director will monitor compliance through random visual inspections (the pipes are exposed and any violations would be easily seen). 5. Sprinkler head replacement will be completed by 5.28.14. 	05/28/2014			

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	<p>C wing hallway had paint on the deflector.</p> <p>c. Eight of eight sprinkler heads in the B wing hallway had paint on the deflector.</p> <p>d. Paint was on the sprinkler deflector in the closets of resident rooms 41, 47, and 48.</p> <p>e. Paint was on the sprinkler deflector in the shared bathrooms of resident rooms 44/45, 41/40 and 46/47.</p> <p>f. Paint was on the sprinkler deflector in the alcoves of resident rooms 39 and 45.</p> <p>g. Three ceiling tiles in the soiled laundry room and 1 ceiling tile in the basement central supply storage room were missing which could delay sprinkler system activation in the event of a fire.</p> <p>h. Sprinkler pipe throughout the main hall, B wing and C wing was used to support at least 4 data and/or telephone cables that were zip tied to the sprinkler pipes.</p> <p>Based on interview during the times of the observations, the Maintenance Director acknowledged sprinkler pipe was used to support cables, the sprinklers had paint on the deflectors, and the ceiling tiles were missing in the aforementioned areas.</p> <p>3.1-19(b)</p>			

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K010064 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 13 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. This deficient practice would have a minimal affect on residents, staff and/or visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director at 1:50 p.m. on 04/28/14, the annual maintenance tag attached to the portable fire extinguisher located in the elevator machine room indicated the last annual maintenance procedure for the extinguisher was performed in 2012. Based on interview at the time of observation, the Maintenance Director acknowledged the</p>	K010064	<ol style="list-style-type: none"> 1. Maintenance was completed on the fire extinguisher in question by the Director of Maintenance. 2. All residents had the potential to be affected by the alleged negligent practice but no issues were noted. 3. The Director of Maintenance will ensure that all extinguishers are maintained per applicable NFPA standards and document same in the Building Engines system. 4. The Executive Director will review the documentation in the Building Engines system to ensure code compliance. 5. 5.28.14 	05/28/2014			

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K010069 SS=B	<p>annual maintenance procedure for the aforementioned portable fire extinguisher had not been completed.</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 observation and interview, the facility failed to ensure the grease filters on 1 of 1 kitchen stove hoods was properly positioned to drain the grease into the containers. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1998 Edition, at 3.2.7 says grease filters requiring a specific orientation to drain grease shall be clearly so designated, or the hood shall be constructed so filters cannot be installed in the wrong orientation. This deficient practice could affect kitchen staff and any resident in the nearby beauty shop.</p> <p>Findings include:</p> <p>Based on observation with the Dietary Manager on 04/28/14 at 1:40 p.m., grease baffle filters in the kitchen stove hood were installed horizontally instead of vertically to drain grease from the</p>	K010069	<p>1. The grease baffle filters were properly re-installed immediately and staff have been inserviced on how to install the filters when cleaning the stove hoods. (sign-in sheet attached) 2. All residents had the potential to be affected by the alleged negligent practice but no issues were noted. 3. The Dietary Manager will visually observe the filters for proper placement at least 4 days per week and note the results on the daily rounds tool. 4. The Executive Director will visually observe the filters for correct placement during the weekly kitchen inspection.</p>	05/28/2014	

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K010144 SS=C	<p>exhaust hood. Based on interview at the time of observation, the Dietary Manager acknowledged the baffle grease filters were not installed in the correct orientation.</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>Based on record review and interview, the facility failed to ensure an annual load bank test was conducted for 1 of 1 diesel powered generators that did not meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems.</p> <p>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.</p> <p>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,</p>	K010144	<p>1. Load bank testing was completed on 5.7.14 by H & G services. The report is attached. Load testing will be conducted, per code requirements, on the generator.</p> <p>2. All residents had the potential to be affected by the alleged negligent practice, but there were no known issues.</p> <p>3. The Maintenance Director will ensure that load testing is conducted, per code requirements; load test documentation will be forwarded to the Executive Director for review.</p> <p>4. The Executive Director will review the generator load test results. Results of these reviews will be presented monthly at the QAPI meeting times 90 days. If after 90 days of review, no trends or patterns are identified (three deficient</p>	05/28/2014	

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	<p>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>Chapter 6-4.2.2 of NFPA 110, requires diesel-powered EPS installations that do not meet the requirements of Chapter 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of generator documentation with the Maintenance Director from 2:30 p.m. to 3:30 p.m. on 04/28/14, four of the past twelve monthly generator load tests indicated the diesel powered generator was tested at less than 30 percent of the generator nameplate</p>		practices per month is considered a trend), then results will be reviewed quarterly.				

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K010147 SS=E	<p>rating. Based on interview at the time of record review, the Maintenance Director acknowledged the most recent load bank test was dated 03/21/13.</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</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 pieces of medical equipment and high current draw electrical devices were not plugged into powers strips or extension cords as a substitute for fixed wiring. LSC 19.5.1 requires utilities to 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, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect at least 10 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director from 11:30 a.m. to</p>	K010147	<p>1. The window air conditioner is plugged directly into an outlet without the use of an extension cord. The refrigerator in room 41 no longer is connected to an extension cord. The nebulizer in room 44 is plugged directly into an outlet rather than a power strip. 2. All residents had the potential to be affected by the alleged negligent practice but no issues were noted. 3. Guardian Angel rounds include the requirement to check that power strips and extension cords are utilized appropriately. (Copy Attached) Results of these rounds will be monitored by the Maintenance Director. 4. The Executive Director will monitor compliance through review of the Guardian Angel rounds forms. Results of these reviews will be presented monthly at the QAPI meeting, times 90 days. If after 90 days of review, no trends or patterns are identified (three</p>	05/28/2014	

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K010160 SS=E	<p>2:30 p.m. during a tour of the facility on 04/28/14, the following was noted:</p> <p>a. A window air conditioner was plugged into an extension cord in the B wing nurses station.</p> <p>b. A refrigerator was plugged into a power strip in resident room # 41.</p> <p>c. A nebulizer was plugged into a power strip in resident room # 44.</p> <p>Based on interview at the times of observation, the Maintenance Director acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 basement elevator equipment rooms was provided with an electrical shunt trip when provided with sprinkler coverage. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of</p>	K010160	<p>deficient practices per month is considered a trend), then results will be reviewed quarterly.</p> <p>1. Contracts have been let to SafeCare and Otis for the installation of the shunt trip in the elevator room (copies attached) Work will commence and should be completed by 5.28.14. 2. All residents had the potential to be affected by the alleged negligent practice but no issues were</p>	05/28/2014			

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K010211 SS=B	<p>ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon, or prior to, the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect residents as well as staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility at 1:55 p.m. on 04/28/14, the basement elevator equipment room was provided with a sprinkler. Based on interview at the time of observation, the Maintenance Director acknowledged a shunt trip for the elevator machine room sprinkler was not provided.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites</p>		<p>noted. 3. The Director of Maintenance will ensure that all work is completed per code requirements and report on same to the Executive Director. 4. The Executive Director will ensure that the work has been completed by the two vendors by reviewing the completed work orders. 5. 5.28.14</p>				

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	<p>of rooms)</p> <ul style="list-style-type: none"> o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>Based on observation and interview, the facility failed to ensure 1 of 1 alcohol based hand rub dispensers on B wing was not installed over an ignition source. This deficient practice could affect at least 10 residents and staff on B wing.</p> <p>Findings include:</p> <p>Based on observation on 04/28/14 with the Maintenance Director at 1:10 p.m., an alcohol based hand rub dispenser containing 70 % alcohol was mounted on the corridor wall between resident rooms 35 and 36 directly above an electrical outlet. Based on an interview with the Maintenance Director at the time of observation, it was acknowledged the alcohol based hand sanitizer dispenser was mounted directly above an ignition source.</p> <p>3.1-19(b)</p>	K010211	<p>1. The hand sanitizer unit has been relocated; it is no longer above an ignition source 2. All residents had the potential to be affected by the alleged negligent practice but no issues were noted. 3. The Director of Maintenance will ensure that any hand sanitizer units that are installed in the future, will not be placed above an ignition source. 4. The Executive Director will make random visual observations of the placement of hand sanitizer units to ensure appropriate placement. 5. 5.28.14</p>	05/28/2014			