

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/27/2015
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NAME OF PROVIDER OR SUPPLIER SEYMOUR CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274
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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: 10/27/15</p> <p>Facility Number: 000272 Provider Number: 155377 AIM Number: 100274710</p> <p>At this Life Safety Code survey, Seymour Crossing 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 fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 115 and had a census of 95 at the time of this visit.</p>	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and that the facility be approved for paper compliance.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0025 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had two detached wooden storage sheds and a detached thirteen hundred square foot residential home used for storage which were not sprinkled.</p> <p>Quality Review completed 10/30/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 8 attic smoke barriers was maintained to provide a one half hour fire resistance rating. This deficient practice could affect 28 residents who reside on the West B Hall.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K 0025	<p>1.) What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? Maintenance has fire caulked all penetrations on 11/02/15. Fire rated caulk was installed to all areas of concern by the maintenance director on 11/02/15. 2.) How will other residents having the potential to be affected by the same deficient practice be identified and what</p>	11/02/2015

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K 0029 SS=C Bldg. 01	<p>maintenance supervisor on 10/27/15 at 12:45 p.m., the West B Hall attic smoke barrier wall had three, two inch gaps around sprinkler water pipe and electrical conduit penetrations with no fire stopping material used to seal the gaps. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 10/27/15 at 1:00 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾</p>		<p>corrective action or actions will be taken? All residents have the potential to be affected by the alleged deficient practice. Fire rated caulk has been installed to all areas of concern by the maintenance supervisor on 11/02/15 and we now have no gapping issues. Other areas were inspected and no other issues were noted. 3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Routine round will be conducted by the maintenance supervisor and or designee to ensure that all areas having gaps are corrected with fire rated caulk. 4.) How will the corrective action (s) be monitored to ensure the deficient practice will not recur? ie: what quality assurance program will be put into place? This will be monitored through quarterly inspections and the environmental CQI conducted monthly for six months to ensure that all gaps are corrected. Any issues identified during the quarterly inspection or monthly CQI's will be addressed timely by the maintenance supervisor and or designee. This will be reviewed by the quality assurance committee and action plans developed for any area that needs to be addressed.</p>		

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	<p>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>1. Based on observation and interview, the facility failed to ensure 1 of 1 sprinklered laundry room was separated from the Service Hall by smoke resistant partitions. This deficient practice affects all staff who work in the Service Hall.</p> <p>Findings include:</p> <p>Based on observation on 10/27/15 at 10:20 a.m. with the maintenance supervisor, the laundry room south wall had one foot by ten inch area of drywall missing and crumbling along the wall floor juncture and the north wall had a four foot by ten inch area of drywall missing and crumbling along the wall floor juncture. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 10/27/15 at 1:00 p.m.</p> <p>3.1-19(b)</p>	K 0029	<p>1.) What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? Maintenance supervisor repaired the area of missing dry wall on the south wall of the laundry room as well as the missing dry wall on the north wall of the laundry room on 11/03/15. Maintenance supervisor placed a self closing door hinge on the dry storage room door on 11/06/15. 2.) How will others having the potential to be affected by the same deficient practice be identified and what corrective action (s) will be taken? All staff working in the service hall have the potential to be affected by this deficient practice. Areas to laundry room walls have been repaired by maintenance supervisor on 11/3/15. Self closing hinge was placed on the dry storage area door on 11/06/15. Other areas were inspected and no other areas with these issues were noted. 3.) What measures will be put into place or what systemic changes</p>	11/06/2015

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K 0038 SS=E Bldg. 01	<p>2. Based on observations and interview, the facility failed to ensure 1 of 3 corridor doors to combustible storage rooms over 50 square feet in the Service Hall was provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect all staff who work in the Service Hall.</p> <p>Findings include:</p> <p>Based on observation on 10/27/15 at 10:30 a.m. with the maintenance supervisor, the Service Hall kitchen food storage supply room, which measured eighty square feet and used for storage of ten shelves of combustible cardboard boxes of dry food products lacked a self closing device on the door. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 10/27/15 at 1:00 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p>		<p>will be made to ensure that the deficient practice (s) do not recur? Routine rounds will be conducted by the maintenance supervisor and or designee to ensure that self closures are operating and that walls are free from any missing dry wall. 4.) How will the corrective actions be monitored to ensure the deficient practice will not recur, ie: what quality assurance program will be put into place? This will be monitored through quarterly inspections and the environmental CQI conducted monthly for 6 months to ensure that all corrections were made. Any issues identified during the quarterly inspections or monthly CQI will be addressed timely by the maintenance supervisor and or designee. This will be reviewed by the quality assurance committee and action plan or plans developed for any area or areas that need to be addressed.</p>	

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	<p>Based on observation and interview, the facility failed to ensure 1 of 11 exits was readily accessible at all times. This deficient practice could affect 74 residents who use the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 10/27/15 at 11:25 a.m., the main dining room exit discharged onto a concrete sidewalk which connected to the Administration Hall front exit sidewalk. Furthermore, the Administration Hall front exit had a four foot high fence on the north side of the concrete pad extending onto the dining room sidewalk where the Administration Hall and dining room sidewalks met which reduced the dining room sidewalk width from four feet to one foot. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 10/27/15 at 1:00 p.m.</p> <p>3.1-19(b)</p>	K 0038	<p>1.) What corrective action or actions will be accomplished for those residents found to have been affected by the deficient practice? Maintenance dug out and framed the area to widen the sidewalk that was obstructed by the fence. Thus reducing the width of the sidewalk. The maintenance supervisor then mixed and poured cement to widen the sidewalk making the exit accessible at all times. This was completed by the maintenance supervisor on 11/05/15.2.) How will other residents having the potential to be affected by this same deficient practice be identified and what action or actions will be taken? All residents have the potential to be affected by this same deficient practice. This walkway is now widened and accessible to everyone at all times since corrected by maintenance supervisor on 11/05/15.3.) What measures will be put into place or systemic changes will be made to ensure that the deficient practice does not recur? Routine rounds will be conducted by the maintenance supervisor and or designee to ensure that the walkway is accessible at all times. 4.) How will the corrective action or actions be monitored to ensure the deficient practice will not recur? ie: What quality assurance program will be put into place? This will be monitored through quarterly inspections and the</p>	11/05/2015	

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K 0046 SS=F Bldg. 01	<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, record review and interview, the facility failed to ensure 1 of 1 battery backup light was tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. 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</p>	K 0046	<p>environmental CQI conducted monthly for 6 months to ensure the walkway is accessible to everyone at all times. Any issues identified during the quarterly inspections or monthly CQI will be addressed by the maintenance supervisor and or designee. This will be reviewed by the quality assurance committee and action plan or plans developed for any area or areas that need addressed.</p> <p>1.) What corrective action or actions will be accomplished for those residents found to be affected by the deficient practice? The maintenance supervisor has added the battery operated emergency light to the battery operated emergency lighting log. This battery operated emergency light will be tested at 30 day intervals for not less than 30 seconds and an annual test will be performed for not less than 1 and 1 half hours. Equipment shall be fully operational for the duration of the test. 2.) How will other residents having the potential to be affected by this same deficient practice be identified and what action or actions will be taken? All residents have the potential to be affected by this same deficient</p>	11/12/2015

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K 0047 SS=C Bldg. 01	<p>kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the event of the battery backup light failure in the emergency generator room during periods of power outages.</p> <p>Findings include:</p> <p>Based on record review on 10/27/15 at 9:20 a.m. with the maintenance supervisor, the Battery Operated Emergency Lighting Log 2014 and 2015 for the emergency generator battery backup light was reviewed and lacked a monthly test for April, May, June, July, August, and September 2015. Furthermore, there was no documented ninety minute annual test of the battery backup light over the past year. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 10/27/15 at 1:00 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on record review and interview,</p>	K 0047	<p>practice. The maintenance supervisor will conduct and record the results of the emergency testing of this battery operated emergency light. 3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Routine rounds and review of record logs will be conducted by the maintenance supervisor and or designee. 4.) How will the corrective actions be monitored to ensure the deficient practice does not recur? Written records of the visual inspection and tests will be kept by the maintenance supervisor. These records will be reviewed monthly by the maintenance supervisor and or designee. Any issues will be addressed in a timely manner by the maintenance supervisor and or designee.</p> <p>1.) What corrective action or actions will be accomplished for</p>	10/27/2015			

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	<p>the facility failed to ensure 1 of 12 exits was provided with a continuously illuminated exit sign served by the emergency lighting system.</p> <p>This deficient practice could affect all staff that work in the Service Hall and would use the Service Hall exit during an evacuation.</p> <p>Findings include:</p> <p>Based on observation on 10/27/15 at 11:45 a.m. with the maintenance supervisor, the Service Hall exit was not provided with an illuminated exit sign above the exit door. Furthermore, the floor plan provided by the maintenance supervisor at the entrance conference on 10/27/15 at 9:10 a.m. indicated the Service Hall exit as a marked exit on the floor plan and the evacuation map mounted on the wall in the Service Hall corridor. Based on an interview with the maintenance supervisor on 10/27/15 at 11:55 a.m., it was stated the illuminated exit sign above the Service Hall exit door was taken down about six months ago. The lack of an illuminated exit sign above the Service Hall exit door was verified by the maintenance supervisor at the time of observation and interview and acknowledged by the administrator at the exit conference on 10/27/15 at 1:00 p.m.</p>		<p>those residents found to have been affected by the deficient practice? An illuminated exit sign was installed at the service hall exit door by the maintenance supervisor on 10/27/15. 2.) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action or actions will be taken? This deficient practice has the potential to affect all staff that work in the service hall area. Other areas were inspected and no other issues were noted pertaining to the exit. 3.) What measures will be taken or systemic changes made to ensure that the deficient practice does not recur? Maintenance supervisor has installed an illuminated exit sign. Routine rounds will be made by maintenance supervisor and or designee to ensure that the sign is functioning properly.4.) How will the corrective action or actions be monitored to ensure the deficient practice does not recur? Maintenance supervisor will make routine rounds and perform visual inspections and keep records as required.</p>	

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K 0051 SS=E Bldg. 01	<p>3.1-19(b)</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 12 exits was provided with a manual fire alarm box located within 5 foot of the exit. LSC 9.6.1.4 refers to NFPA 72, the National Fire Alarm Code. NFPA 72, 2-8.2.2 requires manual fire alarm boxes shall be located within 5 ft of the exit doorway opening at each exit on each floor. This deficient practice affects all residents in the facility in the event of a fire in the Service Hall.</p>	K 0051	<p>1.) What corrective actions will be accomplished for those residents found to be affected by the deficient practice? Van Guard was notified by the maintenance supervisor of the need for placement of the fire pull station at back service hall exit door. Van Guard inspected, measured and is scheduled to return to place fire pull station.</p> <p>2.) How will other residents having the potential to be affected by the</p>	11/26/2015

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K 0061 SS=F Bldg. 01	<p>Findings include:</p> <p>Based on observation on 10/27/15 at 11:45 a.m. with the maintenance supervisor, the Service Hall exit was not provided with a manual fire alarm box within five feet of the exit door. Furthermore, the floor plan provided by the maintenance supervisor at the entrance conference on 10/27/15 at 9:10 a.m. indicated the Service Hall exit as a marked exit on the floor plan and the evacuation map mounted on the wall in the Service Hall corridor. The lack of a manual fire alarm box within five feet of the Service Hall exit was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 10/27/15 at 1:00 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed.</p>		<p>same deficient practice be identified and what corrective action or actions will be taken? All residents have the potential to be affected by this deficient practice in the event of a fire in the service hall. Maintenance Supervisor has contacted Van Guard for replacement of fire pull station to be within five feet of the service hall exit door.</p> <p>3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Fire pull station will be placed by Van Guard. Required inspections will be monitored by Maintenance supervisor per LSC guidelines.</p> <p>4.) How will the corrective action or actions be monitored to ensure the deficient practice will not recur? The required inspections will be monitored by the maintenance supervisor per LSC guidelines. Any issues identified will be addressed timely by the maintenance supervisor and or designee. This will be reviewed by the quality assurance committee, and action plan or plans developed for any area or areas of concern.</p>				

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	<p>NFPA 72, 9.7.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Post Indicator Valve (PIV) was provided with an electrical alarm which alarmed when the valve was closed. LSC Section 9.7.2.1 requires supervisory attachments to be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. This deficient practice affects all residents in the facility if the water to the sprinkler system was shut off and not detected due to lack of supervision.</p> <p>Findings include:</p> <p>Based on observation on 10/27/15 at 11:50 a.m. with the maintenance supervisor, the post indicator valve, which was located outside the Service Hall exit, had an electrical conduit running along the side of the post indicator valve. Furthermore, the electrical conduit was broken and separated from the electrical alarm box and the electrical conduit did not contain electrical wiring and an electrical connection to the post indicator valve alarm. Based on an interview with the maintenance supervisor on 10/27/15 at</p>	K 0061	<p>What corrective actions will be accomplished for those residents found to be affected by the deficient practice? Van Guard was notified by the maintenance supervisor of the need to reconnect electrical alarm to one of one post indicator valve (PIV) requiring supervisory attachments to be installed and monitored for integrity in accordance with NFPA 72 of the national fire alarm code. Van Guard inspected and is scheduled to return to complete work.</p> <p>2.) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action or actions will be taken? All residents have the potential to be affected by this deficient practice. Maintenance supervisor has contacted Van Guard of the need to reconnect the electrical alarm to one of one post indicator valve (PIV) requiring supervisory attachments to be installed and monitored for integrity in accordance with NFPA 72 of the national fire alarm code. Van Guard inspected and is scheduled to return to complete work.</p> <p>3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Van Guard will restore electrical alarm box to electrical wiring connection to post indicator valve (PIV) alarm per code.</p> <p>4.) How will the corrective actions</p>	11/26/2015			

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K 0062 SS=E Bldg. 01	<p>the time of observation, the maintenance supervisor stated he did not know the post indicator valve did not have an electrical connection to the attached alarm box. The lack of the post indicator valve having an electrical connection to the alarm box was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 10/27/15 at 1:00 p.m.</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>1. Based on observation and interview, the facility failed to ensure 1 of 1 kitchen was provided with sprinklers with similar temperature classification which operate in a timely manner and achieve effective fire control. NFPA 13, 1999 Edition, Standard for the Installation of Sprinkler Systems, 5-1.1 states the requirements for spacing, location, and position of sprinklers shall be based on the following principles: (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. NFPA 13, Table</p>	K 0062	<p>be monitored to ensure the deficient practice does not recur? I.e: what quality assurance program will be put into place? This will be monitored by the maintenance supervisor and or designee through quarterly inspections and the environmental CQI conducted monthly for six months to ensure post indicator valve (PIV) wiring is intact. This will be reviewed by the quality assurance committee and action plan or plans developed for any area (s) that need addressed.</p> <p>1.) What corrective actions will be accomplished for those residents found to be affected by the deficient practice? All affected sprinklers will be replaced by Van Guard/Armor a representative from armor came to Seymour Crossing on 11/06/15. Representative here 11/09/15 and completed replacement of sprinklers.</p> <p>2.) How are other residents having the potential to be affected by the same deficient practice identified? What corrective action or actions will be taken? All residents have the potential to be affected by the</p>	11/09/2015	

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	<p>3-2.5.1 describes Ordinary sprinklers as having a temperature rating of 135 to 170 degrees Fahrenheit (F) and Intermediate sprinklers as having a temperature rating of 175 to 225 degrees F. This deficient practice could affect 74 residents who use the main dining room, located adjacent to the main dining room.</p> <p>Findings include:</p> <p>Based on observation on 10/27/15 at 11:35 a.m. with the maintenance supervisor, the kitchen had seven intermediate sprinklers with a temperature rating of two hundred twelve degrees and one ordinary sprinkler with a temperature rating of one hundred sixty degrees in the same room. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 10/27/15 at 1:00 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 1 of over 300 sprinklers in the facility covered in paint. 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</p>		<p>alleged deficient practice. All affected sprinklers have been replaced by Van Guard/Armor. All affected sprinklers have been replaced on 11/09/15.</p> <p>3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Routine rounds will be conducted by the Maintenance supervisor and or designee to ensure that all sprinklers pass inspection.</p> <p>4.) How are the corrective actions to be monitored to ensure the deficient practice will not recur? le: What quality assurance program will be put into place? This will be monitored through quarterly inspections and the environmental CQI conducted monthly for six months to ensure that sprinklers affected are corrected. Any issues identified during the quarterly inspections or the environmental monthly CQI will be addressed timely by the maintenance supervisor and or designee. This will be reviewed by the quality assurance committee and action plans developed for any area or areas needing to be addressed.</p>	

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K 0144 SS=F Bldg. 01	<p>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 74 residents who use the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observations on 10/27/15 at 10:40 a.m. with the maintenance supervisor, the kitchen had one sprinkler above the food preparation table completely covered in white paint. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 10/27/15 at 1:00 p.m.</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. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generator was conducted using one of the three following methods: under operating temperature conditions, at not less than</p>	K 0144	<p>1.) What corrective actions will be accomplished for those residents found to be affected by the deficient practice? The generator has been replaced effective 10/06/15.</p> <p>2.) How will other residents having</p>	11/09/2015

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	<p>30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators 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. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on an interview and review of the Monthly Generator Load Test Log with the maintenance supervisor on 10/27/15 at 9:20 a.m., the Monthly Generator Load Test Log dating from January 2015 to September 2015 listed a monthly load</p>		<p>the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? This deficient practice has the potential to affect all residents, staff and visitors. The generator has been replaced effective 10/06/15. The Maintenance supervisor will document and record a ninety minute load test every month per manufacturer's guidelines and document in the generator load test log. The maintenance supervisor will do an exercise function test weekly to monitor for routine function of the generator and this will documented in the generator load test log. Generator has pre set formula for load test results.</p> <p>3.) What measures will be taken or systemic changes made to ensure that the deficient practice does not recur? The generator has been replaced by Van Guard effective 10/06/15. The Maintenance supervisor will document and record a ninety minute load test every month per manufacturer's guidelines and document in the generator load test log. The maintenance supervisor will do an exercise function test weekly to monitor for routine function of the generator and this will documented in the generator load test log. Generator has pre set formula for load test results.</p> <p>4.) How will the corrective action or actions be monitored to be sure the deficient practice does not recur?</p>	

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	<p>test of the emergency generator with a percent of load documented ranging from 8.1 kilowatts to 8.7 kilowatts. Furthermore, the Monthly Generator Load Test Log indicated the 175 kilowatt emergency generator nameplate rating of thirty percent load test minimum of 52.5 kilowatts. Based on an interview with the maintenance supervisor on 10/27/15 at 9:40 a.m., the Monthly Generator Load Test Log thirty percent load test results were documented incorrectly and the calculation for percent of load was wrong. The lack of the Monthly Generator Load Test Log indicating a percent of load of thirty percent of the emergency generator nameplate rating from January 2015 to September 2015 was verified by the maintenance supervisor at the time of record review and interview, and acknowledged by the administrator at the exit conference on 10/27/15 at 1:00 p.m.</p> <p>3.1-19(b)</p>		<p>The generator has been replaced by Van Guard effective 10/06/15. The Maintenance supervisor will document and record a ninety minute load test every month per manufacturer's guidelines and document in the generator load test log. The maintenance supervisor will do an exercise function test weekly to monitor for routine function of the generator and this will documented in the generator load test log. Generator has pre set formula for load test results.</p>		