

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/11/2015
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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/11/15</p> <p>Facility Number: 000070 Provider Number: 155149 AIM Number: 100266190</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Harcourt Terrace Nursing and Rehabilitation 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 III (211) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to</p>	K010000	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 requests a Post Survey Review on or after March 5, 2014.	

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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K010020 SS=D	<p>the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 110 and had a census of 105 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 02/17/15.</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 Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. Based on observation and interview, the facility failed to enclose 1 of 3 vertical openings with construction having a fire resistance rating of at least one hour. LSC 8.2.5.2 requires openings shall be protected as appropriate for the fire</p>	K010020	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p>	03/05/2015			

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	<p>resistance rating of the barrier. LSC 7.1.3.2.1(a) requires a one hour rating in existing buildings of three stories or less. 7.1.3.2.1(c) requires openings in separations shall be protected by fire door assemblies. NFPA 80, the Standard for Fire Doors and Fire Windows, 1999 Edition, at 2-1.4.1 requires swinging doors to be equipped with self closing devices which will cause the door to close and latch each time it is opened. This deficient practice could affect five staff and visitors in the vicinity of the basement stairwell.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 2:40 p.m. on 02/11/15, the basement stairwell door at the top of the stairwell had a one hour fire resistance rating and was provided with a functional self closing device but the latching mechanism failed to protrude into the door frame. Based on interview at the time of observation, the Maintenance Supervisor stated the spring for the latching mechanism malfunctioned and acknowledged the basement stairwell door at the top of the stairwell failed to latch into the door frame.</p>		<p><b>Hartwood adjusted the latch on the basement door and it latched to the door frame.</b></p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p><b>All residents have the potential to be affected by the alleged deficient practice.</b></p> <p><b>Maintenance Director audited all doors to ensure they latch to the door frame appropriately.</b></p> <p><b>Maintenance Director will audit vertical openings with construction having a fire resistance rating of at least one hour to ensure they latch to the door frames appropriately.</b></p> <p><b>ED/Designee will educate the Maintenance Director on ensuring that all doors in facility are enclosed by March 5, 2015.</b></p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p><b>Maintenance Director will audit vertical openings weekly x 4 and monthly thereafter to</b></p>	

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K010029 SS=D	3.1-19(b)  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		<p><b>ensure they are enclosed.</b></p> <p><b>ED/Designee will educate the Maintenance Director on ensuring that all vertical openings in facility are enclosed by March 5, 2015.</b></p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p><b>Maintenance Director will audit vertical openings weekly x 4 and monthly thereafter to ensure they are enclosed.</b></p> <p><b>The CQI Committee will review the results to make sure all vertical openings are enclosed.</b></p> <p><b>If compliance is not achieved, an action plan will be developed to ensure compliance.</b></p>		

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	<p>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 1 of 9 hazardous areas such as central or bulk laundries greater than 100 square feet in size were separated from other areas by self closing doors. Doors to hazardous areas are self closing or close automatically upon activation of the fire alarm system. This deficient practice could affect 5 staff and visitors in the vicinity of the basement laundry room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 2:40 p.m. on 02/11/15, the entry door to the Clean Laundry Room from the basement corridor was not equipped with a self closing device. Based on interview at the time of observation, the Maintenance Supervisor stated a self closing device had been removed from the door and acknowledged the entry door to the Clean Laundry Room from the basement corridor was not equipped with a self closing device.</p> <p>3.1-19(b)</p>	K010029	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>The Maintenance Director put a self closing device on the entry door to the Clean Laundry Room from the basement corridor.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>Staff and visitors have the potential to be affected by the alleged deficient practice.</p> <p>Maintenance Director has audited all hazardous areas greater than 100 square feet in size to ensure they are separated from other areas by self closing doors.</p> <p>ED/Designee will educate Maintenance Director on ensuring all hazardous areas greater than 100 square feet in size are separated from other areas by self closing doors by</p>	03/05/2015

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			<p><b>March 5, 2015.</b></p> <p><b>1 x weekly, Maintenance Director will audit all hazardous areas greater than 100 square feet in size to ensure they are separated from other areas by self closing doors.</b></p> <p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p><b>ED/Designee will educate Maintenance Director on ensuring all hazardous areas greater than 100 square feet in size are separated from other areas by self closing doors by March 5, 2015.</b></p> <p><b>1 x weekly, Maintenance Director will audit all hazardous areas greater than 100 square feet in size to ensure they are separated from other areas by self closing doors.</b></p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p><b>Maintenance Director will audit</b></p>	

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K010033 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>Based on observation and interview, the facility failed to enclose 1 of 1 stairways with construction having a fire resistance rating of at least one hour. LSC 8.2.5.2 requires openings shall be protected as appropriate for the fire resistance rating of the barrier. LSC 7.1.3.2.1(a) requires a one hour rating in existing buildings of three stories or less. 7.1.3.2.1(c) requires openings in separations shall be protected by fire door assemblies. NFPA 80, the Standard for Fire Doors and Fire</p>	K010033	<p><b>vertical openings weekly x 4 and monthly thereafter to ensure all hazardous areas greater than 100 square feet in size to ensure they are separated from other areas by self closing doors.</b></p> <p><b>The CQI Committee will review the results to make sure all vertical openings are enclosed. If compliance is not achieved, an action plan will be developed to ensure compliance.</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p><b>Hartwood adjusted the latch on the basement door and it latched to the door frame.</b></p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what</b></p>	03/05/2015

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	<p>Windows, 1999 Edition, at 2-1.4.1 requires swinging doors to be equipped with self closing devices which will cause the door to close and latch each time it is opened. This deficient practice could affect five staff and visitors in the vicinity of the basement stairwell.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 2:40 p.m. on 02/11/15, the basement stairwell door at the top of the stairwell had a one hour fire resistance rating and was provided with a functional self closing device but the latching mechanism failed to protrude into the door frame. Based on interview at the time of observation, the Maintenance Supervisor stated the spring for the latching mechanism malfunctioned and acknowledged the basement stairwell door at the top of the stairwell failed to latch into the door frame.</p> <p>3.1-19(b)</p>		<p><b>corrective action will be taken?</b></p> <p><b>All residents have the potential to be affected by the alleged deficient practice.</b></p> <p><b>Maintenance Director will audit the basement door weekly to ensure they latch to the door frames appropriately.</b></p> <p><b>ED/Designee will educate the Maintenance Director on ensuring that all doors in facility are enclosed by March 5, 2015.</b></p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p><b>Maintenance Director will audit the basement door weekly x 4 and monthly thereafter to ensure they are enclosed.</b></p> <p><b>ED/Designee will educate the Maintenance Director on ensuring that all vertical openings in facility are enclosed by March 5, 2015.</b></p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p><b>Maintenance Director will audit</b></p>		

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 3 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their</p>	K010038	<p><b>the basement door weekly x 4 and monthly thereafter to ensure they are enclosed.</b></p> <p><b>The CQI Committee will review the results to make sure all vertical openings are enclosed.</b></p> <p><b>If compliance is not achieved, an action plan will be developed to ensure compliance.</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p><b>The Maintenance Director posted the 4 digit entrance codes at the main entrance door, the northwest exit door, and the Alzheimer's entrance door.</b></p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p>	03/05/2015			

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	<p>safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 62 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 2:40 p.m. on 02/11/15, the exit door at the main entrance, the northwest exit door by Room 25 and the entrance to the Alzheimer's Wing by the south nurses station were each marked as a facility exit with an exit sign. Each exit door was magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of the observations, the Maintenance Supervisor stated the main entrance is unlocked during the day but is locked from 6:00 p.m. to 6:00 a.m. each day. In addition, the Maintenance Director stated not all residents in each smoke compartment, other than the Alzheimer's Wing, have a clinical diagnosis requiring specialized security measures and acknowledged the four digit code was not posted at each of aforementioned three facility exits. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let</p>		<p><b>Resident, staff, and visitors have the potential to be affected by the alleged deficient practice.</b></p> <p><b>Maintenance Director has audited all exit doors to ensure the 4 digit code is posted.</b></p> <p><b>ED/Designee will educate Maintenance Director to ensure that the 4 digit codes are posted at each exit door.</b></p> <p><b>Maintenance Director will audit each exit door weekly x 4 and monthly thereafter to ensure the 4 digit codes are posted.</b></p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p><b>ED/Designee will educate Maintenance Director to ensure that the 4 digit codes are posted at each exit door.</b></p> <p><b>Maintenance Director will audit each exit door weekly x 4 and monthly thereafter to ensure the 4 digit codes are posted.</b></p> <p><b>How the corrective action (s)</b></p>	

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K010051 SS=E	<p>them out if they did not know the code.</p> <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</p>		<p><b>will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p><b>Maintenance Director will audit each exit door weekly x 4 and monthly thereafter to ensure the 4 digit codes are posted.</b></p> <p><b>The CQI Committee will review the results to make sure all vertical openings are enclosed.</b></p> <p><b>If compliance is not achieved, an action plan will be developed to ensure compliance.</b></p>				

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	<p>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 8 exit door electromagnetic locks connected to the fire alarm system remained unlocked while the fire alarm was activated. LSC 9.6.1.3 says the provisions of 9.6 cover the basic functions of a complete fire alarm system. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 3-9.7.1 states any device or system intended to actuate the locking or unlocking of exits shall be connected to the fire alarm system serving the protected premises. NFPA 72, 3-9.7.2 states all exits connected in accordance with 3-9.7.1 shall unlock upon receipt of any fire alarm signal by means of the fire alarm system serving the protected premises.</p> <p>Exception: Where otherwise required or permitted by the authority having jurisdiction.</p> <p>This deficient practice could affect 48 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 2:40 p.m.</p>	K010051	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p><b>The electromagnetic lock on the exit door to the Alzheimer's wing was adjusted by Vanguard and now remains unlocked while the fire alarm system is activated.</b></p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p><b>Resident's, staff, and visitors have the potential to be affected by the alleged deficient practice.</b></p> <p><b>Maintenance Director/Designee will audit all electromagnetic locks on exit doors to ensure they remained unlocked while the fire alarm is activated by March 5, 2015.</b></p> <p><b>The ED/Designee will educate Maintenance Director on ensuring that all electromagnetic locks on exit doors remain unlocked while the fire alarm is activated.</b></p>	03/05/2015	

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	<p>on 02/11/15, the electromagnetic lock on the facility exit to the Alzheimer's Wing by the south nurses station did not remain unlocked when the fire alarm system was activated at 2:19 p.m. The exit door to the Alzheimer's Wing was marked as a facility exit with an exit sign. After activation of the fire alarm system at the aforementioned time and subsequent silencing of the system, all electromagnetic locks in the building at facility exits remained unlocked except for the facility exit to the Alzheimer's Wing. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the electromagnetic lock on the the facility exit to the Alzheimer's Wing did not remain unlocked while the fire alarm system was activated.</p> <p>3.1-19(b)</p>		<p><b>Maintenance Director/Designee will audit all electromagnetic locks on exit doors to ensure they remained unlocked while the fire alarm is activated weekly x 4 and monthly thereafter.</b></p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p><b>The ED/Designee will educate Maintenance Director on ensuring that all electromagnetic locks on exit doors remain unlocked while the fire alarm is activated.</b></p> <p><b>Maintenance Director/Designee will audit all electromagnetic locks on exit doors to ensure they remained unlocked while the fire alarm is activated weekly x 4 and monthly thereafter.</b></p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</b></p>		

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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K010062 SS=F	<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 record review, observation and interview; the facility failed to ensure quarterly sprinkler inspections were conducted for the sprinkler system for 1 of 4 calendar quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code to be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25,</p>	K010062	<p><b>i.e., what quality assurance program will be put into place?</b></p> <p><b>Maintenance Director/Designee will audit all electromagnetic locks on exit doors to ensure they remained unlocked while the fire alarm is activated weekly x 4 and monthly thereafter.</b></p> <p><b>The CQI Committee will review the results.</b></p> <p><b>If compliance is not achieved, an action plan will be developed to ensure compliance.</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p><b>The sprinkler system has been inspected by Armor Fire Protection in the first quarter of 2015.</b></p> <p><b>The internal pipe will be</b></p>	03/05/2015

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	<p>Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor from 9:30 a.m. to 11:45 a.m. on 02/11/15, the fourth quarter (October, November, December) 2014 sprinkler system inspection report was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated the facility switched sprinkler system contractors in 2014 and Vanguard Alarm Systems performed its first inspection under the contract as documented in "Quarterly Sprinkler Inspection Report" dated 01/20/15. Based on observation with the Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 2:40 p.m. on 02/11/15, calendar quarter sprinkler inspection tags were not affixed to the sprinkler system riser in the basement. Based on interview at the time of record review and observation, the</p>		<p><b>inspected by Armor Fire Protection by March 5, 2015.</b></p> <p><b>The fire hydrant will be inspected by Armor Fire Protection</b></p> <p><b>There are spare upright sprinklers with side deflectors available in facility.</b></p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p><b>Residents, staff, and visitors have the potential to be affected by the alleged deficient practice.</b></p> <p><b>ED will develop system to ensure inspections are on schedule for the sprinkler system, the internal pipe, and the fire hydrant by March 5, 2015.</b></p> <p><b>Maintenance Director will have a schedule to ensure the sprinkler system is inspected quarterly by March 5, 2015.</b></p> <p><b>Maintenance Director will have a schedule to ensure the internal pipe is inspected every 5 years by March 5, 2015.</b></p> <p><b>Maintenance Director will create a calendar to ensure the</b></p>				

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	<p>Maintenance Supervisor acknowledged documentation of the fourth quarter 2014 sprinkler system inspection was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler systems was inspected every five years as required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 10-2.2 states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor from 9:30 a.m. to 11:45 a.m. on 02/11/15, documentation of an internal pipe inspection for the facility's automatic</p>		<p><b>fire hydrant is inspected annually by March 5, 2015.</b></p> <p><b>Maintenance Director will conduct an audit monthly to ensure there are the appropriate amount of spare upright sprinklers with side deflectors available in the facility.</b></p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p><b>ED will develop system to ensure inspections are on schedule for the sprinkler system, the internal pipe, and the fire hydrant by March 5, 2015.</b></p> <p><b>Maintenance Director will have a schedule to ensure the sprinkler system is inspected quarterly by March 5, 2015.</b></p> <p><b>Maintenance Director will have a schedule to ensure the internal pipe is inspected every 5 years by March 5, 2015.</b></p> <p><b>Maintenance Director will create a calendar to ensure the fire hydrant is inspected annually by March 5, 2015.</b></p>		

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	<p>sprinkler system within the most recent five year period was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged documentation of an internal pipe inspection for the facility's automatic sprinkler system within the most recent five year period was not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 2:40 p.m. on 02/11/15, "system flushed by JA Fire Prot 11/09" was written on the sprinkler system riser in the basement. Based on interview at the time of observation, the Maintenance Supervisor acknowledged it has been more than five years since the most recent internal pipe inspection had been performed.</p> <p>3.1-19(b)</p> <p>3. Based on record review, observation and interview; the facility failed to ensure 1 of 1 private fire hydrants was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and</p>		<p><b>Maintenance Director will conduct an audit monthly to ensure the appropriate amount of spare upright sprinklers with side deflectors are available in the facility.</b></p> <p><b>Executive Director will educate Maintenance Director to ensure that sprinkler systems are inspected quarterly, the internal pipe is inspected every 5 years, the fire hydrant is inspected annually, and there are the appropriate amount of spare upright sprinklers with side deflectors in the facility.</b></p> <p><b>Maintenance Director will audit the sprinkler system schedule monthly to ensure inspection is done timely.</b></p> <p><b>Maintenance Director will audit the internal pipe system yearly to insure inspection is done timely.</b></p> <p><b>Maintenance Director will audit the fire hydrant calendar quarterly to ensure inspection is done timely.</b></p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p><b>Maintenance Director will audit the sprinkler system schedule</b></p>				

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	<p>after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor from 9:30 a.m. to 11:45 a.m. on 02/11/15, documentation of facility fire hydrant inspection within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated the facility owned one fire hydrant which is located near the north access road and acknowledged documentation of facility owned fire hydrant inspection within the most recent twelve month period was not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 2:40 p.m. on 02/11/15, one facility owned fire hydrant was noted near the north access road.</p> <p>3.1-19(b)</p> <p>4. Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the</p>		<p><b>monthly to ensure inspection is done timely.</b></p> <p><b>Maintenance Director will audit the internal pipe system yearly to insure inspection is done timely.</b></p> <p><b>Maintenance Director will audit the fire hydrant calendar quarterly to ensure inspection is done timely.</b></p> <p><b>Maintenance Director will conduct an audit monthly to ensure the appropriate amount of spare upright sprinklers with side deflectors are available in the facility.</b></p> <p><b>The CQI Committee will review the results to ensure that sprinkler systems are inspected quarterly, the internal pipe is inspected every 5 years, the fire hydrant is inspected annually, and there are the appropriate amount of spare upright sprinklers with side deflectors in the facility and within compliance.</b></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/11/2015
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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 2:40 p.m. on 02/11/15, upright sprinklers with side deflectors were installed in the sprinkler system in the basement corridor. No spare upright sprinklers with side deflectors were located on the premises in the spare sprinkler cabinet in the sprinkler riser room in the basement. In addition, two sidewall spare sprinklers were located in the spare sprinkler</p>			

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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K010066 SS=D	<p>cabinet with one of the sprinklers having a bent deflector. A sidewall sprinkler was noted installed in the automatic sprinkler system outside the basement exit door at the ramp. Based on interview at the time of observation, the Maintenance Supervisor acknowledged no spare upright sprinklers with side deflectors were located on the premises in the spare sprinkler cabinet and one of two sidewall spare sprinklers had a bent deflector.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/11/2015	
NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260			
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	<p>smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container with a self closing lid at 1 of 1 outside areas where smoking was permitted. This deficient practice could affect two staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 2:40 p.m. on 02/11/15, the outdoor smoking area located outside the kitchen exit had in excess of 100 extinguished cigarette butts deposited on the ground. A metal container with a self closing cover device into which ashtrays can be emptied was not provided in this area where staff smoking was taking place. Based on interview at the time of the observation, the Maintenance Supervisor acknowledged extinguished cigarette butts were deposited on the ground and a metal container with a self closing cover device into which ashtrays can be emptied was not provided in this area where staff smoking was taking place.</p> <p>3.1-19(b)</p>	K010066	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Maintenance Director has removed all cigarette butts from the ground.</p> <p>A metal container with a self closing cover is in the smoking area.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>Staff have the potential to be affected by the alleged deficient practice.</p> <p>Maintenance Director/Designee will check the smoking area daily (Monday-Friday) and Manager on Duty (Saturday-Sunday) to ensure cigarette butts are not on the ground and instead disposed of in a metal container with a self closing lid.</p> <p><b>What measures will be put into place or what systemic changes you will make to</b></p>	03/05/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/11/2015
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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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			<p><b>ensure that the deficient practice does not recur?</b></p> <p><b>Maintenance Director/Designee will check the smoking area daily (Monday-Friday) and Manager on Duty (Saturday-Sunday) to ensure cigarette butts are not on the ground and instead disposed of in a metal container with a self closing lid.</b></p> <p><b>Executive Director will inservice Maintenance Director on ensuring cigarette butts are not disposed of on the ground and ensuring there is a metal container with a self closing cover device available.</b></p> <p><b>Maintenance Director will educate staff on ensuring they do not dispose of cigarette butts on the ground but in the metal containter with a self closing lid.</b></p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p><b>Maintenance Director/Designee will conduct weekly rounds x 4 and monthly rounds thereafter.</b></p> <p><b>If compliance is not achieved, an action plan will</b></p>	

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K010069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>1. Based on record review and interview; the facility failed to ensure 1 of 1 kitchen range hood fire extinguishing equipment was maintained in accordance with NFPA 96. LSC 9.2.3 refers to NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, Section 7-4.1 states upon activation of any fire-extinguishing system for a cooking operation, all sources of fuel and electric power that produce heat to all equipment requiring protection by that system shall automatically shut off. This deficient practice could affect five staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on review of Vanguard Alarm Services "Periodic Range Hood Suppression System Testing and Inspection Report" documentation dated 01/20/15 with the Maintenance Supervisor from 9:30 a.m. to 11:45 a.m. on 02/11/15, the most recent range hood fire extinguishing equipment inspection</p>	K010069	<p><b>be developed to ensure compliance.</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p><b>Edwards will properly install the gas valves by March 5, 2015.</b></p> <p><b>The Maintenance Director adjusted the baffles in the kitchen range hood and they are now installed at an angle not less than 45 degrees from the horizontal.</b></p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p><b>Staff and visitors have the potential to be affected by the alleged deficient practice.</b></p> <p><b>Maintenance Director/Designee will inspect the kitchen range hood weekly x 4 and monthly</b></p>	03/05/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/11/2015
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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>"Comments" section stated "Gas valve did not shut. Gas Valve line link is improperly installed into the control heads. Electrical appliances did not shut down when the system was activated". Based on interview at the time of record review, the Maintenance Supervisor stated documentation of corrections to the range hood fire extinguishing equipment on or after 01/20/15 was not available for review and acknowledged corrections to the range hood fire extinguishing equipment had not been performed.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 kitchen exhaust system baffles were installed correctly. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 3-2.5 states filters shall be installed at an angle not less than 45 degrees from the horizontal. This deficient practice could affect five staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 2:40 p.m.</p>		<p><b>thereafter to ensure the gas valve shuts and the baffles in the range are installed correctly.</b></p> <p><b>Maintenance Director will review Vanguard reports from the previous year to ensure appropriate follow up has been done if needed.</b></p> <p><b>Executive Director will inservice Maintenance Director to ensure that the gas valve shuts, baffles are installed correctly, and there is appropriate and timely follow up on inspection reports.</b></p> <p><b>Executive Director will review all range hood fire extinguishing equipment inspection reports to ensure there is appropriate and timely follow up done.</b></p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p><b>Executive Director will inservice Maintenance Director to ensure that the gas valve shuts, baffles are installed correctly, and there is appropriate and timely follow up on inspection reports.</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  02/11/2015	
NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260			
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K010074 SS=C	<p>on 02/11/15, four of eight baffles in the kitchen range hood are aligned horizontally in the kitchen range hood exhaust system. Based on interview at the time of observation, the Maintenance Supervisor acknowledged four of eight baffles in the kitchen range exhaust hood are aligned horizontally.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance</p>		<p><b>Executive Director will review all range hood fire extinguishing equipment inspection reports to ensure there is appropriate and timely follow up done.</b></p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p><b>Executive Director will review all range hood fire extinguishing equipment inspection reports to ensure there is appropriate and timely follow up done.</b></p> <p><b>If compliance is not achieved, an action plan will be developed to ensure compliance.</b></p>				

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	<p>with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on record review, observation and interview; the facility failed to ensure valences in 7 of 7 smoke compartments were flame resistant. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor from 9:30 a.m. to 11:45 a.m. on 02/11/15, documentation of valence flame resistance documentation was not available for review. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 2:40 p.m. on 02/11/15, valences installed in each smoke compartment in the facility had no affixed documentation stating each valence was inherently flame retardant. Based on interview at the time of record review and of the observations, the Maintenance Supervisor stated valences are not treated with a flame retardant material and acknowledged documentation for flame retardant</p>	K010074	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p><b>If documentation is not obtained, Maintenance Director will treat all valences installed in smoke compartments with a flame retardant material by March 5, 2015.</b></p> <p><b>Documentation has been obtained to show that the valences are flame retardant.</b></p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p><b>Residents, staff, and visitors have the potential to be affected by the alleged deficient practice.</b></p> <p><b>Maintenance Director/Designee will treat all valences installed in smoke compartments with a flame retardant material.</b></p> <p><b>Maintenance Director will ensure that documentation is obtained to show that valences are flame retardant.</b></p> <p><b>Executive Director will inservice Maintenance Director to ensure that valences are</b></p>	03/05/2015



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	<p><b>OTHER LSC DEFICIENCY NOT ON 2786</b></p> <p>Based on record review, observation and interview; the facility failed to ensure the care and maintenance of 2 of 2 rolling fire doors were in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 30 residents, staff and visitors in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor from 9:30 a.m. to 11:45 a.m. on 02/11/15, documentation of kitchen rolling fire door inspection and testing within the most recent twelve month period was not</p>	K010130	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>The kitchen rolling fire door has been tested and inspected by Vanguard and tags are available for review.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>Staff and visitors the potential to be affected by the alleged deficient practice.</p> <p>Maintenance Director will set a schedule for the kitchen rolling fire doors to be tested annually.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p>Maintenance Director/Designee will set a schedule for the kitchen rolling fire doors to be tested annually.</p>	03/05/2015

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K010147 SS=E	<p>available for review. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 2:40 p.m. on 02/11/15, one metal rolling fire door protecting the opening from the kitchen to the Main Dining Room was noted. In addition, a second metal rolling fire door separates the dishwashing room from the corridor which leads to the employee exit by the ramp. No inspection tag was affixed to either of the two rolling fire doors. Based on interview at the time of record review and of the observations, the Maintenance Supervisor acknowledged documentation of kitchen rolling fire door inspection and testing within the most recent twelve month period was not available for review.</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 extension cords including power strips were not used as a substitute for fixed wiring.</p>	K010147	<p><b>Executive Director will inservice Maintenance Director to ensure the kitchen rolling fire doors are inspected annually.</b></p> <p><b>Maintenance Director will audit calendar quarterly to ensure the kitchen rolling fire door is inspected annually.</b></p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p><b>Executive Director will inservice Maintenance Director to ensure the kitchen rolling fire doors are inspected annually.</b></p> <p><b>Maintenance Director will audit calendar quarterly to ensure the kitchen rolling fire door is inspected annually.</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient</b></p>	03/05/2015			

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	<p>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. LSC Section 4.5.6 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 1999 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 7-5.2.2.1 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 24 residents, staff and visitors in the vicinity of Room 38.</p> <p>Findings include:</p> <p>Based on observation with the</p>		<p><b>practice?</b></p> <p><b>Room 38 no longer has a power strip in the room.</b></p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p><b>Residents, Staff, and Visitors have the potential to be affected by the alleged deficient practice.</b></p> <p><b>Maintenance Supervisor/Designee will audit all resident rooms to ensure that there are no power strips in use.</b></p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p><b>Maintenance Supervisor/Designee will audit all resident rooms to ensure that there are no power strips in use.</b></p> <p><b>Maintenance Director will inservice staff on not using power strips in rooms.</b></p> <p><b>Maintenance Director will use room rounds tool weekly x 4 and monthly thereafter to</b></p>	

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	<p>Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 2:40 p.m. on 02/11/15, the resident bed and an air mattress were plugged into a power strip under the resident bed in Room 38. Based on interview at the time of observation, the Maintenance Supervisor acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned locations.</p> <p>3.1-19(b)</p>		<p><b>ensure that no power strips are in use.</b></p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p><b>Maintenance Director will use room rounds tool weekly x 4 and monthly thereafter to ensure no power strips are in use.</b></p> <p><b>If compliance is not achieved, an action plan will be developed to ensure compliance.</b></p>				