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 01/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(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	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). Survey Date: 01/10/14 Facility Number: 000070 Provider Number: 155149 AIM Number: 100266190 Surveyor: Mark Caraher, Life Safety Code Specialist 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. 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	K010000	Harcourt Terrace Nursing and Rehabilitation submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employee, agents, officers, or directors. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceeding on that basis. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests paper compliance review in lieu of a Post Survey Review on or after	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	levels in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 116 and had a census of 96 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/14/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:		February 9, 2014.	

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K010018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 3 of over 75 corridor doors did not have an impediment to closing and latching and would resist the passage of smoke. This deficient practice could affect 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:35 p.m. to 4:00 p.m. on 01/10/14, a kick down door stop was attached to each of two corridor doors to the Therapy Room and was in use propping each door open. In addition, the corridor door to the Salon had a kick down door stop attached to the door.	K010018	K018 NFPA 101 LIFE SAFETY CODE STANDARD · Corrective Action: On January 14, 2014 the kick down door stops was removed from each of the two corridor doors to the Therapy Room and the corridor door to the Salon. · Identification of Other Residents at Risk: All residents have the potential to be affected by this alleged deficient practice. A review of all corridor doors in the facility were inspected to ensure the doors did not have an impediment to closing and latching. · Measures/Systematic Changes: On January 22, 2014, the Director of Maintenance Consultant re-educated the Maintenance Supervisor regarding protecting corridor doors from any impediment to the closing of doors. The Maintenance	02/09/2014

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	Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned corridor doors each had a kick down door stop attached to the door which provided an impediment to closing and latching. 3.1-19(b)		Supervisor will conduct weekly facility rounds to ensure corridor doors do not have an impediment to closing and latching. · Monitor: To ensure compliance, the Maintenance Director/Designee is responsible for completion of the Life Safety CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The CQI committee overseen by the Executive Director (ED) will review the results of these audits. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
K010025 SS=B	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 Based on observation and interview, the facility failed to ensure 1 of 2 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 5 staff and visitors in the	K010025	K025 NFPA 101 LIFE SAFETY CODE STANDARD · Corrective Action: On January 14, 2014, the two inch in diameter annular space surrounding two separate electrical conduits which penetrated the ceiling of the	02/09/2014

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	kitchen. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 12:35 p.m. to 4:00 p.m. on 01/10/14, the two inch in diameter annular space surrounding two separate electrical conduits which penetrated the ceiling of the Dietary Managers Office in the kitchen exposed the attic above and did not provide at least a one half hour fire resistance rating. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned openings in the ceiling smoke barrier in the Dietary Managers Office did not provide at least a one half hour fire resistance rating. 3.1-19(b)		Dietary Managers Office in the Kitchen was sealed using Fire Barrier sealant. · Identification of Other Residents at Risk: All residents have the potential to be affected by this alleged deficient practice. All smoke barriers in the facility were inspected to ensure smoke barriers are constructed and repaired to provide at least a one half hour fire resistance rating. · Measures/Systematic Changes: On January 22, 2014, the Director of Maintenance Consultant re-educated the Maintenance Supervisor regarding smoke barriers are constructed to provide at least a one half hour fire resistance rating and repairing any identified penetrations with Fire Barrier sealant. The Maintenance Supervisor will conduct weekly facility rounds to ensure smoke barriers are constructed and repaired to provide at least a one half hour fire resistance rating. · Monitor: To ensure compliance, the Maintenance Director/Designee is responsible for completion of the Life Safety CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The CQI committee overseen by the ED will review the results of these audits. If threshold of 95% is not achieved	

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			an action plan will be developed to ensure compliance.	
K010027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 4 of 9 sets of smoke barrier doors would provide a smoke resistant barrier. LSC 19.3.7.6 requires doors in smoke barriers shall comply with Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 74 residents, staff and visitors if smoke was allowed to move from one smoke compartment to another. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:35 p.m. to 4:00 p.m. on 01/10/14, each door equipped with an astragal in each set of smoke barrier	K010027	K027 NFPA 101 LIFE SAFETY CODE STANDARD · Corrective Action: On January 14, 2014, the one quarter inch wide by three inch high rectangular hole in the astragal was sealed on each set of smoke barrier doors in the corridor by Room 1, Room 11, Room 31 and Room 37. · Identification of Other Residents at Risk: All residents have the potential to be affected by this alleged deficient practice. All smoke barrier doors were inspected to ensure the doors were constructed or repaired to provide at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. · Measures/Systematic Changes: On January 22, 2014, the Director of Maintenance Consultant re-educated the Maintenance Supervisor regarding smoke barrier doors are constructed and repaired to provide at least a 20-minute fire	02/09/2014

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	doors in the corridor by Room 1, Room 11, Room 31 and Room 37 had a one quarter inch wide by three inch high rectangular hole in the astragal which did not provide a smoke resistant barrier when the aforementioned smoke barrier door sets were closed. Based on interview at the time of the observations, the Maintenance Director acknowledged each set of the aforementioned smoke barrier doors failed to provide a smoke resistant barrier when closed. 3.1-19(b)		protection rating or are at least 1¾-inch thick solid bonded wood core. The Maintenance Supervisor will conduct weekly facility rounds to ensure smoke barrier doors are constructed and repaired to provide at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. · Monitor: To ensure compliance, the Maintenance Director/Designee is responsible for completion of the Life Safety CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The CQI committee overseen by the ED will review the results of these audits. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the	K010029	K029 NFPA 101 LIFE SAFETY	02/09/2014

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	facility failed to ensure 1 of 9 doors serving hazardous areas such as trash collection rooms is provided with self closing devices to close and latch the door into the door frame. This deficient practice could affect 30 residents, staff and visitors in the Main Dining Room. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 12:35 p.m. to 4:00 p.m. on 01/10/14, the Biohazard Room trash collection room which is in the same smoke compartment as the Main Dining Room was not equipped with a self closing device on the entry door from the corridor to close and latch the door into the door frame. Two cardboard boxes with biohazard waste were observed being stored in the room. Based on interview at the time of observation, the Maintenance Director acknowledged the Biohazard Room is a trash collection room and the entry door from the corridor was not equipped with a self closing device to close and latch the door into the door frame. 3.1-19(b)		CODE STANDARD · Corrective Action: On January 14, 2014, a self closing device was attached to the door to the Biohazard Room. · Identification of Other Residents at Risk: All residents have the potential to be affected by this alleged deficient practice. All doors serving hazardous areas were inspected to ensure that the doors are equipped with self closing devices to close and latch the door into the door frame. · Measures/Systematic Changes: On January 22, 2014, the Director of Maintenance Consultant re-educated the Maintenance Supervisor regarding separating hazardous areas from other spaces by smoke resisting partitions and doors that are self-closing and latch to the door frame. The Maintenance Supervisor will conduct weekly facility rounds to ensure hazardous areas are separated from other spaces by smoke resisting partitions and doors that are self-closing and latch to the door frame. · Monitor: To ensure compliance, the Maintenance Director/Designee is responsible for completion of the Life Safety CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The CQI committee	

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			overseen by the ED will review the results of these audits. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
K010050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to document activation of the fire alarm system for fire drills conducted between 6:00 a.m. and 9:00 p.m. on the second and third shift for 2 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility. Findings include:	K010050	K050 NFPA 101 LIFE SAFETY CODE STANDARD · Corrective Action: The facility will conduct fire drills to include transmission of the fire alarm signal between the hours of 6:00 a.m. and 9:00 p.m. by February 9, 2014. · Identification of Other Residents at Risk: All residents have the potential to be affected by this alleged deficient practice. The facility will conduct fire drills to include transmission of the fire alarm signal between the hours of 6:00 a.m. and 9:00 p.m. by February 9, 2014. · Measures/Systematic Changes: On January 14, 2014, the Executive Director re-educated the Maintenance Supervisor regarding conducting fire drills at unexpected times under varying conditions, at least quarterly on each shift and to include	02/09/2014

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	Based on review of "Monthly Fire Drill Report" documentation during record review with the Maintenance Director from 9:30 a.m. to 12:00 p.m. on 01/10/14, documentation for the second shift fire drill conducted at 8:30 p.m. on 08/28/13 and the third shift fire drill conducted at 7:00 a.m. on 12/29/13, each conducted after 6:00 a.m. but before 9:00 p.m., did not include transmission of the fire alarm signal. The aforementioned second shift fire drill documentation stated "alarm not set off due to time of night" and the aforementioned third shift fire drill documentation stated "education with all night staff, didn't set off alarm until 10:05 a.m." Based on interview at the time of record review, the Maintenance Director acknowledged documentation for the aforementioned second and third shift fire drills conducted after 6:00 a.m. and before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal. 3.1-19(b)		transmission of the fire alarm signal between the hours of 6:00 a.m. and 9:00 p.m. The facility will conduct fire drills to include transmission of the fire alarm signal between the hours of 6:00 a.m. and 9:00 p.m. at least quarterly on each shift.· Monitor: To ensure compliance, the Maintenance Director/Designee is responsible for completion of the Monthly Fire Drill Report. This report will be reviewed by the ED weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. CQI committee overseen by the ED will review the results of these drills. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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K010052 SS=C	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 observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice	K010052	K052 NFPA 101 LIFE SAFETY CODE STANDARD · Corrective Action: The fire alarm system breaker was identified and marked on January 17, 2014. The “E/M Panel” was locked on January 24, 2014. · Identification of Other Residents at Risk: All residents have the potential to be affected by this alleged deficient practice. The fire alarm system breaker was identified and marked on January 17, 2014. The “E/M Panel” was locked on January 24, 2014. · Measures/Systematic Changes: On January 22, 2014, the Director of Maintenance Consultant re-educated the Maintenance Supervisor regarding maintain and testing the fire alarm system specifically marking and locking/sealing the fire alarm system breaker and panel. · Monitor: To ensure compliance, the Maintenance Director/Designee is responsible for the completion of the Life Safety CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is	02/09/2014

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	could affect all residents, staff and visitors. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 12:35 p.m. to 4:00 p.m. on 01/10/14, the fire alarm system breaker could not be located or identified. Based on interview at the time of observation, the Maintenance Director stated the fire alarm system breaker should be in the "E/M Panel" in the janitor's closet in the kitchen but no breaker in the "E/M Panel" was identified as a fire alarm system breaker and the aforementioned panel was not locked or sealed. The Maintenance Director acknowledged the fire alarm system breaker could not be located or identified. 3.1-19(b)		maintained for 2 consecutive quarters. The CQI committee overseen by the ED will review the results of these audits. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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K010062 SS=C	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 1. Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the 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. Findings include: Based on observation with the Maintenance Director at 11:15 a.m. on	K010062	K062 NFPA 101 LIFE SAFETY CODE STANDARD · Corrective Action: 1) The spare sprinkler was purchase on January 13, 2014. (2) The escutcheon plates of the sprinklers in the Laundry Room were replaced on January 23, 2014. · Identification of Other Residents at Risk: All residents have the potential to be affected by this alleged deficient practice. (1) The Maintenance Manager will have at least six spare sprinklers and a minimum of two sprinklers of each type stored in the facility for replacement purposes. (2) The Maintenance Manager inspected all sprinkler heads to ensure that an escutcheon plates were placed on each sprinkler. · Measures/Systematic Changes: On January 22, 2014, the Director of Maintenance Consultant re-educated the Maintenance Supervisor regarding having at least six spare sprinklers and a minimum of two sprinklers of each type stored in the facility for replacement purposes and that Sprinkler Systems are maintained with escutcheon plates. The Maintenance Manager will inspect weekly the cabinet were spare	02/09/2014

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	01/10/14, a total of five spare sprinklers were located in the spare sprinkler cabinet in the sprinkler riser room in the basement Laundry. In addition, only one sidewall spare sprinkler was located in the aforementioned spare sprinkler cabinet. During a tour of the facility from 12:35 p.m. to 4:00 p.m. on 01/10/14, sidewall sprinklers were installed under the exterior canopy at the basement ramp door exit and in the laundry chute in the basement. Based on interview at the time of the observations, the Maintenance Director acknowledged sidewall sprinklers were installed in the facility, a total of five spare sprinklers were located on the premises for the facility and only one spare sidewall sprinkler was located on the premises in the spare sprinkler cabinet. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 7 of 9 sprinkler heads in the Laundry were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect two staff and visitors in the Laundry.		sprinkler heads are to ensure we have at least six spare sprinklers and a minimum of two sprinklers of each type stored in the facility for replacement purposes. The Maintenance Manager will inspect monthly all sprinkler systems to ensure the systems are maintain with escutcheon plates. · Monitor: To ensure compliance, the Maintenance Director/Designee is responsible for completion of the Life Safety CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The CQI committee overseen by the ED will review the results of these audits. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:35 p.m. to 4:00 p.m. on 01/10/14, seven of nine sprinklers located in the drop ceiling of the basement Laundry had missing escutcheon plates which left a two inch opening in the drop ceiling of the Laundry. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned sprinklers each had missing escutcheon plates which left a two inch opening in the drop ceiling of the basement Laundry. 3.1-19(b)			
K010069 SS=B	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 4 of 4 kitchen range hood fire suppression system	K010069	K069 NFPA 101 LIFE SAFETY CODE STANDARD · Corrective Action: On January 20,	02/09/2014

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	nozzles were provided with blowoff caps or other suitable devices to prevent the entrance of grease vapors into the nozzles. LSC 9.2.3 requires commercial cooking equipment to be in compliance with NFPA 96, 1998 Edition, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 7-2.2.1 requires automatic fire extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable: a. NFPA 12, Standard on Carbon Dioxide Extinguishing Systems b. NFPA 13, Standard for the Installation of Sprinkler Systems c. NFPA 17, Standard for Dry Chemical Extinguishing Systems d. NFPA 17A, Standard for Wet Chemical Extinguishing Systems NFPA 17A, Standard for Wet Chemical Extinguishing Systems, 1998 Edition, 2-3.1.4 states all discharge nozzles shall be provided with caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign materials into the piping. The protection device shall blow off, open, or blow out upon agent discharge. This deficient practice could affect five staff in the kitchen.		2014 the kitchen range hood fire suppression system nozzles were provided with blowoff caps to prevent the entrance of grease vapors into the nozzles. · Identification of Other Residents at Risk: All residents have the potential to be affected by this alleged deficient practice. On January 20, 2014 the kitchen range hood fire suppression system nozzles were provided with blowoff caps to prevent the entrance of grease vapors into the nozzles. · Measures/Systematic Changes: On January 22, 2014, the Director of Maintenance Consultant re-educated the Maintenance Supervisor regarding cooking facilities are protected by fire extinguishing systems particularly fire suppression systems nozzles that have blowoff caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign materials into the piping. The vendor will check bi-annually to ensure that the nozzles are in place. · Monitor: To ensure compliance, the Maintenance Director/Designee is responsible for completion of the Life Safety CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The CQI committee overseen by the ED will review	

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	Findings include: Based on observation with the Maintenance Director during a tour of the facility from 12:35 p.m. to 4:00 p.m. on 01/10/14, each of four kitchen range hood fire suppression system nozzles were not provided with blowoff caps or other suitable devices to prevent the entrance of grease vapors into the nozzles. Based on interview at the time of observation, the Maintenance Director acknowledged the four kitchen range hood fire suppression system nozzles were not provided with blowoff caps or other suitable devices to prevent the entrance of grease vapors into the nozzles. 3.1-19(b)		the results of these audits. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
K010147 SS=E	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 2 of 2 extension cords including power strips were not	K010147	K147 NFPA 101 LIFE SAFETY CODE STANDARD · Corrective Action: On January 20, 2014, the microwave and coffee	02/09/2014

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	used as a substitute for fixed wiring. 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 18 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:35 p.m. to 4:00 p.m. on 01/10/14, a coffee pot and a microwave oven were plugged into a power strip in the pantry by Room 11 and a refrigerator was plugged into a power strip in the Employee Break Room. Based on interview at the time of the observations, the Maintenance Director acknowledged extension cords including power strips were in use as a substitute for fixed wiring at the aforementioned locations. 3.1-19(b)		pot in the pantry by Room 11 was plugged into a fixed outlet. On January 20, 2014, the refrigerator in the Employee Break Room was plugged into a fixed outlet. · Identification of Other Residents at Risk: All residents have the potential to be affected by this alleged deficient practice. The Maintenance Manager conducted a review of the uses of extension cords and power strips to ensure that they meet NFPA standards. · Measures/Systematic Changes: On January 22, 2014, the Director of Maintenance Consultant re-educated the Maintenance Supervisor regarding electrical wiring and equipment are not to be used as a substitute for fixed wiring unless specifically permitted. The Maintenance Manager will conduct weekly rounds to ensure the uses of extension cords and power strips meet NFPA standards. · Monitor: To ensure compliance, the Maintenance Director/Designee is responsible for completion of the Life Safety CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The CQI committee overseen by the ED will review the results of these audits. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	