

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155738	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/06/2012
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NAME OF PROVIDER OR SUPPLIER  MILTON HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 206 E MARION ST SOUTH BEND, IN 46601
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K0000	<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: 06/06/12</p> <p>Facility Number: 001141 Provider Number: 155738 AIM Number: 200905640</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Milton Home 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 two story facility with a basement is partially sprinklered and was determined to be of Type II (111) construction. The original building was constructed in 1952 with the nursing addition located on the first and second floors added in 1975. The facility has a fire alarm system with</p>	K0000		

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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	<p>smoke detection in the corridors, in resident sleeping rooms on the second floor and in all areas open to the corridor. Resident sleeping rooms on the first floor have battery operated smoke detectors. The facility has a capacity of 34 and had a census of 27 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/13/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0011 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 doors on the first floor in the fire barrier wall separating health care from the assisted living occupancy provided the protection needed for a two hour fire barrier. LSC 19.1.1.4.2 refers to LSC 8.2. LSC 8.2.3.2.3.1 requires openings in a 2 hour fire barrier be provided with doors having at least a 1 1/2 hour fire protection rating. This deficient practice could affect residents, staff and visitors in the vicinity of the first floor corridor door separating the health care portion of the facility from Assisted Living area.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:05 p.m. on 06/06/12, the first floor cross corridor door separating the health care portion of the facility from Assisted Living did not display a fire rating of at least one and one half hours required for a door in a two</p>	K0011	<p>1. The first floor fire door, side light and frame that separates Assisted Living from Health Care will be replaced with a latching one and a half hour fire door. II. Replacing the fire door will protect all residents from the same deficient practice. III. The new door will be checked and monitored by the Maintenance supervisor for positive latching and magnetic hold open to ensure continued compliance weekly for 90 days. IV. This will be tracked by the Maintenance supervisor weekly for 90 days for positive latching and magnetic hold open. The results will be reported to the Quaterly QA committee. V. The facility is requesting a waiver for six months making the completion date December 6, 2012 due to the expense and the fact that this is a special size door which will need to be custom made. See attached Waiver</p>	12/06/2012			

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	hour fire wall. Based on interview at the time of observation, the Maintenance Director acknowledged no fire protection rating was listed on the first floor cross corridor door separating the health care portion of the facility from the Assisted Living area.  3.1-19(b)				

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K0015 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to provide documentation of the flame spread rating for interior finish materials installed in 1 of 1 basement Therapy Rooms. This deficient practice could affect any resident, staff or visitor in the Therapy Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:05 p.m. on 06/06/12, the Apartment building structure constructed within the basement Therapy Room had vinyl siding installed on two walls from the floor to the ceiling. Based on interview at the time of observation, the Maintenance Director stated the vinyl siding had not been treated with flame retardant material and acknowledged no flame spread rating documentation was available for review</p>	K0015	<p>I. The Maintenance Supervisor has requested the flame spread rating from the manufacturer. II. The Flame spread rating documentation will protect all residents having the potential to be affected by the deficient practice. III. The maintenance supervisor will monitor monthly to ensure the flame spread rating is in the binder for this room to ensure the same deficient practice does not happen again. IV. This will be monitored by the maintenance supervisor and results reported to the QA committee. V. This will be completed by July 6th.</p>	07/06/2012			

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	for the vinyl siding.  3.1-19(b)			

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K0025 SS=E	<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 7 of 8 first floor resident room closets were maintained to provide at least a one half hour fire resistance rating. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect any resident, staff or visitor in the vicinity of first floor resident Rooms 110 through 114 plus resident Rooms 122 and 123.</p> <p>Findings include:</p> <p>Based on observations with the</p>	K0025	<p>I. The maintenance supervisor has caulked all penetrants in resident rooms 110 through 114 and resident rooms 122 through 123 with a fire rated cauk. II. The maintenance supervisor will check all resident rooms on the nursing units to ensure that no other penetrants exist. III. The maintenance supervisor will check all nursing resident rooms monthly for 90 days to ensure the integrity of the fire barrier caulking. IV. The maintenance supervisor will track results and report findings to the QA committee. This will be completed by July 6th 2012.</p>	07/06/2012	

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	<p>Maintenance Director during a tour of the facility from 11:30 a.m. to 2:05 p.m. on 06/06/12, the 3/4th inch annular space surrounding a two inch in diameter sprinkler pipe which penetrates the corridor wall and room dividing walls into resident room closets in Rooms 110 through 114 and resident Rooms 122 and 123 was not firestopped. Based on interview at the time of observation, the Maintenance Director acknowledged the 3/4th inch annular space surrounding a two inch sprinkler pipe penetrating into the aforementioned resident room closets was not firestopped.</p> <p>3.1-19(b)</p>			

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 3 of 7 doors serving hazardous areas such as soiled linen rooms, rooms with fuel fired heaters and the laundry room are each provided with self closing devices to close and latch the door into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the soiled linen room by Room 221, the basement boiler room and the basement laundry room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:05 p.m. on 06/06/12, the access door to the soiled linen room by Room 221, the basement boiler room and the basement laundry room are not equipped with a self closing</p>	K0029	<p>I. The maintenance supervisor will a self closing device to latch the soiled linen room, the basement boiler room, the basement laundry room, the kitchen entry door from the corridor and the kitchen entry door from the dining room to their frames. The kitchen entry door from the dining room will also have latching device installed. II. The maintenance supervisor will check all self closing doors to ensure that they positively latch. III. The maintenance supervisor will check all self closing doors monthly to ensure the same deficient practice does not occur. IV. The results will be tracked by the maintenance supervisor and results reported to the QA committee. V. This will be completed by July 6th, 2012</p>	07/06/2012			

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	<p>device to latch each door into the door frame. Based on interview at the time of the observations, the Maintenance Director acknowledged the access door to the aforementioned hazardous areas were each not equipped with a self closing device.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 7 doors serving hazardous areas such as the kitchen are provided with a functional positive latching device to latch the door into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen entry door from the corridor and the kitchen entry door from the Dining Room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:05 p.m. on 06/06/12, the kitchen entry door from the Dining Room is not equipped with a positive latching device to latch the door into the door frame, and while the kitchen entry door from the corridor is equipped with a positive latching device, the latching side of the door was hitting the door frame and would not latch into the</p>				

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	<p>door frame. Based on interview at the time of the observations, the Maintenance Director acknowledged the kitchen entry doors were not equipped with a functional positive latching device to latch each door into the door frame.</p> <p>3.1-19(b)</p>			

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K0046 SS=C	<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 observations, record review and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 10 of 10 battery operated emergency lights. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½-hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:05 p.m. on 06/06/12, there are ten battery operated emergency lights located in the facility. Based on record review with the Maintenance Director from 10:00 a.m. to</p>	K0046	<p>I. The maintenance supervisor will document the thirty day functional battery test as well as the annual test for at least 1 and a half hour duration for the ten battery operated emergency lights. II. The maintenance supervisor will conduct a thirty day functional battery test each month. The maintenance supervisor will also conduct the 1 and a half hour annual test and document findings. III. The maintenance supervisor will conduct these monthly and annual inspections and document finding to ensure the same deficient practice does not reoccur. IV. The maintenance supervisor will document findings and report results to the QA committee. V. This will be completed by July 6th</p>	07/06/2012			

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	<p>11:30 a.m. on 06/06/12, documentation of thirty day interval functional testing and annual testing for at least a 1 ½-hour duration for the ten battery operated emergency lights was not available for review. Based on interview at the time of record review, the Maintenance Director stated each battery operated emergency light is tested on a monthly basis but acknowledged there is no documentation available for review of thirty day interval or annual testing for each of the ten battery operated emergency lights in the facility.</p> <p>3.1-19(b)</p>				

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K0048 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice affects any resident, staff and visitor in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of "Emergency Fire Protection" documentation during record review with the Maintenance Director from 10:00 a.m. to 11:30 a.m. on 06/06/12, the facility's written fire safety plan did not address the use of ABC type fire extinguishers and the K-class fire</p>	K0048	<p>I. The fire safety policy will be updated to include the use of the overhead extinguishing system prior to using the K class extinguisher.II. The maintenance supervisor will inservice all of the kitchen staff. III. The maintenance supervisor will inservice any new dietary staff upon hire to the fire safety policy to ensure the same deficient practice does not reoccur.IV. The maintenance supervisor will track results to the QA committee.V. This will be completed by July 6th .</p>	07/06/2012			

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	<p>extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Maintenance Director acknowledged the written fire safety plan for the facility did not include the policy to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K-class fire extinguisher.</p> <p>3.1-19(b)</p>				

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K0050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>1. Based on record review and interview, the facility failed to document the transmission of the fire alarm signal for 2 of 4 fire drills conducted prior to 9:00 p.m. on the second 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. This deficient practice affects all occupants in the facility including residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of "Fire Drill Report" documentation during record review with the Maintenance Director from 10:00 a.m. to 11:30 a.m. on 06/06/12, documentation for the second shift fire drill conducted on 04/04/12 at 7:15 p.m. and the fire drill conducted on 10/09/11 at 5:00 p.m. did not include the transmission of the fire</p>	K0050	<p>I. The Maintenance supervisor will conduct audible fire drills between the hours of 7:00 am and 9:00 pm. Communication with the monitoring company will be checked at the completion of each drill. Documentation will be kept on hand for inspection. The maintenance supervisor will conduct fire drills at unexpected times and under varying conditions. The schedule will be updated for the next twelve months to ensure the drills are conducted at unexpected times and under varying conditions to ensure sufficient response time by employees.II. The Maintenance supervisor will conduct monthly fire drills at unexpected times and under varying conditions to ensure all residents will not be affected by the same deficient practice.III. The maintenance supervisor will review updated annual schedule monthly to ensure the same difficient practice does not reoccur.IV. The maintence</p>	07/06/2012			

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	<p>alarm signal. Written documentation of the 04/04/12 fire drill stated "No" in response to "Transmission of Alarm" and written documentation of the 10/09/11 fire drill was blank for "Transmission of Alarm". Based on interview at the time of record review, the Maintenance Director acknowledged second shift fire drills conducted on 04/04/12 at 7:15 p.m. and 10/09/11 at 5:00 p.m. did not include transmission of the fire alarm signal.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 3 of 4 quarters. This deficient practice affects all occupants in the facility.</p> <p>Findings include:</p> <p>Based on a review of "Fire Drill Report" documentation during record review with the Maintenance Director from 10:00 a.m. to 11:30 a.m. on 06/06/12, first shift fire drills conducted on 06/27/11, 09/16/11 and 03/30/12 were conducted between 1:10 p.m. and 1:40 p.m. Based on interview at the time of record review, the Maintenance Director acknowledged first shift fire drills were not conducted at unexpected times under varying</p>		supervisor will track fire drill reports and communicate findings to the Quarterly Quality Assurance committee.				

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	conditions.  3.1-19(b)				

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K0052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>1. 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 could</p>	K0052	<p>I. The Maintenance supervisor has identified and marked dedicated circuit to the fire alarm panel and the breaker panel containing the fire alarm circuit has been locked. Four of four duct smoke detectors shall be removed and tested for sensitivity annually for the next two years. If sensitivity remains within the marked ranges, sensitivity testing will then be performed every two years per NFPA 72.II. The Maintenance supervisor has identified and marked dedicated circuit to the fire alarm panel and the breaker panel containing the fire alarm circuit has been locked. Four of four duct smoke detectors shall be removed and tested for sensitivity annually for the next two years. If sensitivity remains within the marked ranges, sensitivity testing will then be performed every two years per NFPA 72.III. The maintenance supervisor will check monthly to ensure the marked dedicated circuit panel and the breaker panel containing the fire alarm circuit are locked. Maintenance director will review and monitor the fire sensitivity reports to</p>	07/06/2012			

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	<p>affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:05 p.m. on 06/06/12, access to the fire alarm system breaker located in the unlocked basement boiler room was not locked. The fire alarm system breaker was not locked nor was the breaker panel locked. Based on interview at the time of observation, the Maintenance Director acknowledged access to the fire alarm system breaker located in the basement boiler room was not locked.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 4 of 4 duct smoke detectors are maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests</p>		<p>ensure all smoke detectors have a sensitivity number.IV. The maintenance supervisor will report findings to the quarterly Quality Assurance Committee.V. This will be completed by July 6th.</p>				

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	<p>may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method.</li> <li>(2) Manufacturer's calibrated sensitivity test instrument.</li> <li>(3) Listed control equipment arranged for the purpose.</li> <li>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range.</li> <li>(5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction.</li> </ol> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires inspection, testing and maintenance reports be provided for the owner or a designated representative. It</p>			

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	<p>shall be the responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having jurisdiction. This deficient practice affects 27 of 27 residents, staff and all visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of Fire Alarm System Testing Company (F.A.S.T.) "Device Listing" documentation dated 04/26/11 with the Maintenance Director during record review from 10:00 a.m. to 11:30 a.m. on 06/06/12, documentation of sensitivity testing for four of four duct smoke detectors located in ductwork in the basement air handling room was not available for review. The "Device Listing" documentation is a listing of smoke detector sensitivity testing of facility smoke detectors but the documentation did not include sensitivity testing of the four duct detectors located in the basement air handling room ductwork. Based on observation with the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:05 p.m. on 06/06/12, four duct smoke detectors were observed attached to the ductwork in the basement air handling room. Based on interview at the time of record review, the Maintenance Director stated no other</p>						

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	<p>sensitivity testing documentation for duct smoke detectors was available for review and acknowledged smoke detector sensitivity testing of duct smoke detectors was not available for review.</p> <p>3.1-19(b)</p>			

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K0071 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes:</p> <p>(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5.</p> <p>(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7.</p> <p>(3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4.</p> <p>(4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 laundry chutes, a vertical opening, was provided with automatic extinguishing protection in accordance with LSC 9.7. LSC 9.7 states each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, section 5-13.5 states building service chutes (e.g. linen) shall be protected internally by automatic sprinklers. A sprinkler shall be provided</p>	K0071	<p>I. The maintenance supervisor will close off the existing laundry chute and a fire barrier consisting of two layers of 5/8 inch sheet rock will be installed at the base and between first and second floor. In addition both laundry chute doors shall be removed and two layers of 5/8 inch sheet rock shall be installed as a fire barrier to permanently seal off the chute. II. The maintenance supervisor will close off the existing laundry chute and a fire barrier consisting of two layers of 5/8 inch sheet rock will be installed at the base</p>	07/06/2012			

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	<p>above the top service opening of the chute, above the lowest service opening, and above service openings at alternate levels in buildings over two stories in height. The room or area into which the chute discharges shall also be protected by automatic sprinklers. This deficient practice could affect any of resident, staff or visitor in the vicinity of the first and second floor laundry chute access doors and in the basement laundry room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:05 p.m. on 06/06/12, the laundry chute is not provided with automatic sprinkler protection on any building level. Based on interview at the time of observation, the Maintenance Director acknowledged the laundry chute was not provided with automatic sprinkler protection on any building level.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 laundry chutes, a vertical opening, was enclosed with construction having a fire resistance rating of at least one hour. LSC 9.5.1 states doors of laundry chutes shall only</p>		<p>and between first and second floor. In addition both laundry chute doors shall be removed and two layers of 5/8 inch sheet rock shall be installed as a fire barrier to permanently seal off the chute. This will be done to ensure the safety of all residents having the potential to be affected. III. The maintenace supervisor will check monthly for the next six months to ensure the integrity of the drywall. IV. The maintenance supervisor will report findings to the quarterly quality assurance committee.</p>	

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	<p>open to a room that is designed and used exclusively for accessing the chute opening. The room shall be separated from other spaces in accordance with Section 8.4. LSC 8.4.1.3 states doors in barriers required to have a fire resistance rating shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect any of resident, staff or visitor in the vicinity of the first and the second floor laundry chute access doors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:05 p.m. on 06/06/12, the first and second floor corridor laundry chute access doors were of wood construction, were not fire rated, and each access door was not provided with a self closing device to latch each door into the chute door frame. Based on interview at the time of the observations, the Maintenance Director acknowledged the first and second floor laundry chute access doors in the corridor are not fire rated, are not self closing, and do not latch into the chute door frame.</p> <p>3.1-19(b)</p>			

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K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>(a) Individual visual signals shall indicate:</p> <ol style="list-style-type: none"> <li>1. When the emergency or auxiliary power source is operating to supply power to load.</li> <li>2. When the battery charger is malfunctioning.</li> </ol> <p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:</p> <ol style="list-style-type: none"> <li>1. Low lubricating oil pressure.</li> <li>2. Low water temperature.</li> <li>3. Excessive water temperature.</li> <li>4. Low fuel - when the main fuel storage</li> </ol>	K0144	<p>I. The maintenance supervisor will have a remote annunciator installed by a general contractor (Pauls's generator) to communicate generator status to the first floor nursing station which is maned 24 hours a day 7 days a week. Capabiliity of annunciator will cover the most information available to the make and year of this model. We are requesting a 100 day extension due to the cost and part availabilty. Upon inspection the maintenance supervisor found the inphase transfer switch in the on position. After switching to the off position transfer time is now at 7 seconds. The maintenance supervisor will a remote stop switch installed in the generator control panel located in the basement at the transfer. The maintenance supervisor will install signage at the panel and the generator indicating the location of the stop switch. Installation shall be performed by a generator contractor. II.The maintenance supervisor will have a remote annunciator installed by a general contractor (Pauls's generator) to communicate generator status to the first floor nursing station which is maned 24 hours a day 7 days a week.</p>	09/13/2012			

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	<p>tank contains less than a 3-hour operating supply.</p> <p>5. Overcrank (failed to start).</p> <p>6. Overspeed.</p> <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:05 p.m. on 06/06/12, a remote alarm annunciator for the generator was not provided in a location readily observed by operating personnel at a regular work station such as a nurses' station. Based on interview at the time of the observation, the Maintenance Director acknowledged there was no remote alarm annunciator for the generator in a location readily observed by operating personnel at a regular work station such as a nurses' station.</p>		<p>Capabliity of annunciator will cover the most information available to the make and year of this model. We are requesting a 100 day extension due to the cost and part availability. Upon inspection the maintenance supervisor found the inphase transfer switch in the on position. After switching to the off position transfer time is now at 7 seconds. The maintenance supervisor will a remote stop switch installed in the generator control panel located in the basement at the transfer. The maintenance supervisor will install signage at the panel and the generator indicating the location of the stop switch. Installation shall be performed by a generator contractor. This will ensure the safety of any residents having the potential to be affected. III. The maintenance supervisor will perform a monthly check of annunciator and log in generator test form The maintenace supervisor will devise a form to indicate a maximum time of ten seconds to transfer. IV. The maintenance supervisor will report findings to the quarterly Quality assurance committee. See attached Waiver</p>				

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	<p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 11 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of "Monthly Generator Full Load Test" documentation during record review with the Maintenance Director from 10:00 a.m. to 11:30 a.m. on 06/06/12, monthly load test documentation for the eleven month period of 07/29/11 through 05/31/12 lists the transfer time as ranging between 20 to 35 seconds. Based on interview at the time of record review, the Maintenance Supervisor acknowledged it took more</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155738		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  06/06/2012	
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	<p>than 10 seconds to transfer building power to the emergency generator for 11 of 12 months.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located outside of the room where the prime mover is located. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:05 p.m. on 06/06/12, a remote shut off device was not found for the 10 kilowatt natural gas fired emergency generator. The nameplate on the emergency generator stated the unit was manufactured in June 2003. Based on interview at the time of</p>						

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	<p>observation, the Maintenance Director acknowledged the emergency generator was installed after 2003 and acknowledged there is no remote emergency shut off for the emergency generator.</p> <p>3.1-19(b)</p>						