

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELY AVE ELKHART, IN 46517
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K 000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Dates: 02/10/15 and 02/11/15</p> <p>Facility Number: 000039 Provider Number: 155685 AIM Number: 100275130</p> <p>Surveyors: Amy Kelley, Life Safety Code Specialist, Scott Wytosick, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Elkhart was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered except for the electrical room in the maintenance shop. The original building (North, East and South</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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K 025 SS=D Bldg. 01	<p>Units) was constructed in 1968 with an addition (Primrose and Southwest Units) built in 1975. The facility has a fire alarm system with smoke detection 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 175 and had a census of 147 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered with the exception of the electrical room in the maintenance shop. Quality Review by Dennis Austill, Life Safety Code Specialist on 02/19/15.</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 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</p>			

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	<p>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 the penetrations caused by the passage of wire and/or conduit through 1 of 1 East hall smoke barrier walls was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC 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 18 East hall occupants.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Director on 02/11/15 at 2:51 p.m., a square section of the East hall smoke barrier wall was cut out and removed to allow the sprinkler line with a sprinkler head to be installed directly in the center of the smoke barrier wall. At the time of observation, the Maintenance Director confirmed the sprinkler head was</p>	K 025	<p>It is the practice of this facility to maintain compliance with this life safety standard.</p> <p><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></p> <p>-</p> <p>1) The East Smoke Barrier wall is scheduled for repair after sprinkler is removed on 3-9-15</p> <p>Attachment: I (Fire Improvement Bid)</p> <p>2) South hall generator room citation has been repaired to life safety code standard.</p> <p>-</p> <p><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></p> <p>100% visual inspection of the building with life safety surveyor which no other areas were identified.</p> <p><u>Measures put into place to ensure alleged deficient practice does not recur:</u></p> <p>-</p> <p>All repairs will be monitored and inspected by the maintenance director. to ensure that facility remains in compliance with safety standard.</p> <p><u>How corrective action will be monitored to ensure alleged</u></p>	03/13/2015

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	<p>installed in the center of the smoke barrier wall.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation on 02/11/15 at 2:39 p.m., the Maintenance Director stated there was a section of ceiling measuring seven inches by two inches missing around conduit and another two inch section missing around another conduit above the electrical boxes in the South hall generator room</p> <p>3.1-19(b)</p>		<p><u>deficient practice does not recur:</u></p> <p>- Maintenance Director will be responsible to inspect and monitor all contractors while on site. Maintenance director will submit monthly round reports to the QAPI committee for 3 months and then once a month, quarterly. Any issues/concerns will be addressed as appropriate. QAPI committee will recommend monitoring requirements at that time.</p>		

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K 029 SS=E Bldg. 01	<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, record review and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors at the opening in the kitchen wall, a hazardous area, was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment, or system required for compliance with this Code 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</p>	K 029	<p>It is the practice of this facility to maintain compliance with this life safety standard, including maintaining written records to indicate the system is inspected and tested annually for proper operation and full closure.</p> <p><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></p> <p>- 1)A inspection of the rolling fire door/window has been completed on ().</p> <p>Attachment: A (Inspection report)</p> <p>2.A) (Mark's purposal on the kitchen doors)</p>	03/13/2015
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	<p>instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 30 resident in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 02/10/15 at 11:10 a.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room. Based on the record review of the Overhead Door inspection form, the last annual inspection was conducted on 12/09/13. Based on interview with the Maintenance Director at the time of record review, no other documentation was available for review to confirm the rolling fire door had received an annual inspection since 12/09/13.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Kitchens and 1 of 1 Laundry rooms, both are hazardous areas, were provided with self closer's and would latch into the frame. This deficient practice was not in a resident care area but could affect staff in the service corridor.</p>		<p>2b) Self closing device was added to the door coming from the dish machine to the kitchen.</p> <p>- <u>Identification of other residents with potential to be affected by alleged deficient practice:</u></p> <p>-</p> <p>- <u>Measures put into place to ensure alleged deficient practice does not recur:</u></p> <p>The annual inspection has been arranged automatically with the inspection company to ensure that inspections occur annually per the life safety standard.</p> <p>Inspection records will be maintained in a binder in the administrator office and will be made available when requested.</p> <p><u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></p> <p>- Maintenance Director and Administrator will meet once a month to review the annual inspections due for that month. The Administrator will be responsible to follow-up with this list throughout the month to ensure that inspections are completed. Follow-up lists will be kept in the annual inspection binder, along with the inspection records.</p>				

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K 038 SS=E Bldg. 01	<p>Findings include:</p> <p>a. Based on observations with the Maintenance Director and the Regional Director of Facility Management on 02/11/15 at 10:40 a.m., the two doors entering the laundry room and one door entering the kitchen were large metal sliding door. Based on an interview with the Maintenance Director at the time of observation, the self closing feature on these large metal sliding doors are no longer functional therefore none of the doors would self close and latch into the door frame.</p> <p>b. Based on an observation with the Maintenance Director and the Regional Director of Facility Manager on 02/11/15 at 10:41 a.m., the door entering the kitchen from the dish machine room was in the service corridor wall. At the time of observation, the Maintenance Director acknowledged the door lacked a self closing device.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p>		<p>- Maintenance Director will submit a report of # annual inspections completed and the results to QAPI committee each month for 3 months. At that time the committee will determine if continued monitoring is required.</p>	
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	<p>Based on observation and interview, the facility failed to ensure 1 of 5 East hall doors in the path of egress, equipped with a magnetic locking system, remained unlocked with activation of the building fire protective signaling system. LSC 19.2.1 requires every corridor and exit be in compliance with Chapter 7. LSC 7.2.1.6.2.(d) requires actuation of the fire alarm system shall unlock the doors in the direction of egress and the doors shall remain unlocked until the fire alarm system has been manually reset. This deficient practice could affect any of the East hall residents.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 02/11/14 at 3:15 p.m., the door entering/exiting the East hall, which was equipped with a magnetic locking system, failed to remain unlocked when the fire alarm system was placed in silence mode. Based on an interview at the time of observation, the Maintenance Director confirmed the door entering the East hall would not release until a code was entered into the keypad.</p> <p>3.1-19(b)</p>	K 038	<p>It is the practice of this facility to maintain compliance with this life safety standard, including exits are readily accessible at all times.</p> <p><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u> - SMS Security was called and door was fixed 2-11-15 to remain unlocked with activation of the fire alarm system. Attachment B: (SMS service call report)</p> <p><u>Identification of other residents with potential to be affected by alleged deficient practice:</u> - Fire alarm activation was completed on 2/25/15 by the maintenance department. All doors were checked and found to be functioning as required. Attachment C: (Fire Door Check)<u>Measures put into place to ensure alleged deficient practice does not recur:</u> Maintenance Department will add a check-off audit to the monthly fire drill documentation to show that doors have been checked and are properly functioning each time the fire alarm system has been activated. Attachment d: (Door Audit) <u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u> - The Administrator will sign off fire drills each month after review. The Maintenance Director will report audit results 1 time/monthly during QAPI committee for 3</p>	03/13/2015	

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K 048 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 Based on record review and interview, the facility failed to provide a written plan that included the activation of a resident room battery operated smoke detector in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a record review and interview on 02/10/15 at 12:11 p.m., the</p>	K 048	<p>months. Any non-compliance/concerns will be discussed with the committee for recommendations including further monitoring needs.</p> <p>It is the practice of this facility to maintain compliance with this life safety standard.,</p> <p><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></p> <ul style="list-style-type: none"> - The Emergency Action Fire plan was updated to address activation of resident room battery operated smoke alarms. <p>Attachment: O (Fire Plan-14.7)</p> <p><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></p> <p>All residents have the potential to be affected by alleged deficient practice.</p> <ul style="list-style-type: none"> - <u>Measures put into place to ensure alleged deficient practice does not recur:</u> <p>The Fire Plan will be reviewed with staff on a quarterly basis to ensure that they are aware of what to do to</p>	03/15/2015

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K 050 SS=F Bldg. 01	<p>Maintenance Director acknowledged the "Fire and Disaster Plan" did not address activation of a resident room battery operated smoke detector.</p> <p>3.1-19(b)</p> <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 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p>	K 050	<p>activate the battery operated smoke alarms.</p> <p><u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></p> <p>- The Education Director will interview staff randomly each month to ensure that they are aware of the policy. Results of those interviews will be reported in monthly QAPI for 3 months for identification of additional monitoring recommendations. In-services will be provided as necessary</p> <p>It is the practice of this facility to maintain compliance with this life safety standard, regarding the conduction of fire drills on each shift quarterly and at different times. <u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u> - Maintenance Department have</p>	03/13/2015

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	<p>Based on record review of the "Report of Fire Drill Exercise" with the Maintenance Director and the Maintenance Assistant on 02/10/15 at 10:45 a.m., there was no record of a second shift fire drill for the fourth quarter of 2014. Based on an interview with the Maintenance Director at the time of record review, no other documentation was available for review to verify this drill was conducted.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>been in-serviced regarding state requirements of fire drills and maintaining readily accessible records that are current at all times. Attachment E: (In-service Record for Maintenance Department), <u>Identification of other residents with potential to be affected by alleged deficient practice:</u> Review of current records by the administrator validate that the facility is currently following a schedule and is in compliance with this standard at this time. <u>Measures put into place to ensure alleged deficient practice does not recur:</u> Maintenance has a fire drill schedule in place that has all future fire drills pre-scheduled with times and shifts listed. The administrator has reviewed the schedule and confirms that all shifts with different times have been accounted for. Attachment F: (2015 Fire Drill Schedule) <u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u> The maintenance director will report monthly fire drill results as part of his report to the QAPI committee. The administrator will sign off monthly fire drills acknowledging they are in accordance with the pre-schedule calendar. This process will occur once a month for 3 months, which at that time the QAPI committee will determine if further monitoring is required.</p>		

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K 052 SS=C Bldg. 01	<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>Based on record review and interview, the facility failed to ensure transmission of the fire alarm signal to the monitoring station was verified for 3 of the last 4 completed quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. NFPA 72, 1999 Edition, National Fire Alarm Code at 7-3.2.20 Testing Frequencies of Off-Premises Transmission Equipment requires quarterly testing. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director of "Report of Fire Drill Exercise" on 02/10/15 at 10:45 a.m., the fire alarm inspection documentation, the sprinkler inspection documentation and the fire drill documentation lacked verification of the transmission of the fire alarm signal to</p>	K 052	<p>I</p> <p>It is the practice of this facility to maintain compliance with this life safety standard, including assurance of transmission of the fire alarm signal to the monitoring system.</p> <p><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></p> <ul style="list-style-type: none"> - Fire drill record form was revised to include a section for documentation of the transmission of the fire alarm signal to the monitoring station. - Attachment G: (Fire Drill Record) - <u>Identification of other residents with potential to be affected by alleged deficient practice:</u> - All residents have potential to be affected, however, no residents have experienced negative impact. <p><u>Measures put into place to ensure alleged deficient practice does not recur:</u></p> <ul style="list-style-type: none"> - The Report of Fire Drill Exercise 	03/13/2015			

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	<p>the monitoring station for the second, third and fourth quarters of 2014. Based on interview at the time of review, the Maintenance Director stated no other documentation was available for review.</p> <p>3.1-19(b)</p>		<p>form has been revised to include this information . The maintenance department has been in-serviced on the change.</p> <p>-</p> <p>Attachment H: (In-service Record)</p> <p><u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></p> <p>-</p> <p>The Administrator and Maintenance Director will meet monthly to review the fire drill records to ensure that our fire drills meet fire safety standards. Any concerns/issues that are identified will be reviewed at the monthly QAPI committee for recommendations/solutions. This topic will remain on the QAPI agenda once a month for 3 months, at which time it will be determined if there is a continued need for monitoring.</p> <p>t is the practice of this facility to maintain compliance with this life safety standard, including assurance of transmission of the fire alarm signal to the monitoring system. <u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u> _ Fire drill record form was revised to include a section for documentation of the transmission of the fire alarm signal to the monitoring station._ Attachment G: (Fire Drill Record)_ <u>Identification of other residents</u></p>	

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K 056 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based		<u>with potential to be affected by alleged deficient practice:</u> All residents have potential to be affected, however, no residents have experienced negative impact. <u>Measures put into place to ensure alleged deficient practice does not recur:</u> The Report of Fire Drill Exercise form has been revised to include this information. The maintenance department has been in-serviced on the change. Attachment H: (In-service Record) <u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u> The Administrator and Maintenance Director will meet monthly to review the fire drill records to ensure that our fire drills meet fire safety standards. Any concerns/issues that are identified will be reviewed at the monthly QAPI committee for recommendations/solutions. This topic will remain on the QAPI agenda once a month for 3 months, at which time it will be determined if there is a continued need for monitoring.	

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	<p>Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to ensure complete automatic sprinkler system was provided for 1 of 1 maintenance shop electrical rooms in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building.</p> <p>Exception: Sprinklers shall not be required where all of the following conditions are met: (a) The room is dedicated to electrical equipment only. (b) Only dry-type electrical equipment is used. (c) Equipment is installed in a 2-hour fire-rated enclosure including protection for penetrations. (d) No combustible storage is permitted to be stored in the room. This deficient practice could affect all staff in the service hall.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 02/10/15 at 12:45 p.m., the maintenance shop electrical room lacked sprinkler coverage. Based on an interview at the time of</p>	K 056	<p>It is the practice of this facility to maintain compliance with this life safety standard,</p> <p><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></p> <p>-</p> <p>1a) The electrical room in the maintenance shop was cleaned and freed of combustibile materials on 2-27-15.</p> <p>1b)A new 2-hr rated fire door has been ordered and scheduled to be put in by Mark Hoepfner Construction. upon delivery. The door will meet all code requirements. (Reference to attachment: 1-Replacement Door Bid)</p> <p>1c)Closing device was placed on the electrical room door on 2-27-15.</p> <p>2) Sprinkler heads on the south unit are scheduled to be changed from standard response sprinklers to quick response sprinklers. This work has been scheduled with VFP fire systems slated to begin the week of 3-9 and will continue until completion.</p> <p>3) This issue is also part of the fire protection improvements scheduled</p>	03/20/2015

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	<p>observation, the Maintenance Director confirmed the following regarding the electrical room in the maintenance shop:</p> <p>a) contained storage of combustible material such as; cardboard boxes and lawn care chemicals</p> <p>b) the electrical room was constructed of two layers of five eights inch drywall which does not provide a 2 hour fire rated enclosure with a gap at the top where the wall did not meet the ceiling</p> <p>c) the electrical room door lacked a fire rating and a self closing device</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure only one type of sprinkler head i.e. quick response or standard sprinklers were installed in 1 of 1 South halls. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a smoke compartment shall be changed. This deficient practice could affect all 30 residents in the South hall.</p> <p>Findings include:</p> <p>Based on observations and interview on 02/10/15 at 3:15 p.m. to 3:17 p.m., the</p>		<p>to begin the week of 3-9-15.</p> <p>Attachment I: (Fire Improvement Proposal)</p> <p>- <u>Identification of other residents with potential to be affected by alleged deficient practice:</u></p> <p>Facility Audit of the building sprinkler heads was completed on 2-19-15 with a representation from VFP Fire Systems. Our fire protection improvement proposal was updated to include findings.. This job is scheduled to begin the week of 3-9-15 and will continue until all areas identified have been replaced.</p> <p>- <u>Measures put into place to ensure alleged deficient practice does not recur:</u></p> <p>- The Maintenance Director will review and addition of sprinklers-heads with the contractor prior to work being started to ensure that they are in compliance with the life safety requirements.</p> <p><u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></p> <p>- The Maintenance Department will be responsible to monitor any sprinkler work in progress. The Regional Director of Maintenance</p>	

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	<p>Maintenance Director confirmed the right hall and the dining room in the South hall had a mixture of quick response sprinkler heads with the thin glass bulb and standard response sprinkler heads with the thick glass bulbs. Based on an interview with the Maintenance Director after placing a call to the facilities sprinkler company SafeCare at the time of observations, he stated SafeCare assumed since all South hall sprinkler heads had the same temperature rating, quick response sprinkler heads and standard response sprinkler heads could be commingled.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 2 of 4 sprinkler heads at the South hall nurses' station were separated by at least six feet as required by NFPA 13. NFPA 13 Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect any of the 30 residents in the South hall.</p> <p>Findings include:</p> <p>Based on an observation on 02/10/15 at 2:47 p.m., the Maintenance Director confirmed three of four sprinkler heads at</p>			

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K 066 SS=E Bldg. 01	<p>the South hall nurses' station were mounted 48 inches apart.</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 smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to enforce 1 of 1 smoking policies for the facility. This deficient practice could affect occupants evacuated through the ambulance bay exit.</p>	K 066	<p>It is the practice of this facility to maintain compliance with this life safety standard,</p> <p><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></p>	03/13/2015	

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	<p>Findings include:</p> <p>Based on an observation on 02/11/15 at 11:40 a.m., the Maintenance Director stated there were at least 40 cigarette butts on the ground commingled with discarded trash and dried leaves outside the ambulance bay exit. At the time of observation, the Maintenance Director confirmed the ambulance bay exit was not a designated smoking area.</p> <p>3.1-19(b)</p>		<ul style="list-style-type: none"> - The ambulance area was cleared of cigarette butts. <p>Staff and residents have been notified of the facility's intent to enforce the facility smoking policy via direct memos and meetings.</p> <p>Attachment: J (Smoking Policy Memo)</p> <ul style="list-style-type: none"> - <u>Identification of other residents with potential to be affected by alleged deficient practice:</u> <p>Maintenance department made complete rounds outside the building and cleaned up any areas that had cigarette butts.</p> <ul style="list-style-type: none"> - <u>Measures put into place to ensure alleged deficient practice does not recur:</u> <ul style="list-style-type: none"> - Implementation of ground rounds by management. Additional focus on communication of the current smoking policy with staff via in-service. <p>Random off-shift visits will occur at different times, different days(twice wkly) to ensure that staff are complying with the policy..</p> <p>Any staff found to be smoking will receive disciplinary actions/ up to and including termination.</p> <p>Resident smoking will be supervised</p>	

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K 067 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Service hall egress corridors was not being used as a portion of the supply air plenum for heating, ventilating and air conditioning ductwork (HVAC) serving adjoining areas. NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice was not in a resident care area but could affect facility staff in the service hall.</p> <p>Findings include:</p>	K 067	<p>per the facility policy.</p> <p><u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></p> <p>- The Maintenance Director will follow up with the Administrator wkly regarding the audit results. These results will be added to the monthly QAPI for 3 months at which that time it will be determined the need for additional monitoring.</p> <p>See attached wavier request.</p>	03/13/2016	

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K 069 SS=E Bldg. 01	<p>Based on an observation with the Maintenance Director and the Regional Director of Facility Management on 02/11/15 at 11:00 a.m., the service hall was provided with only supply vents. Based on an interview at the time of observation, the Maintenance Director and the Regional Director of Facility Management confirmed the returns vents for the service corridor ventilation system were located in the housekeeping office, breakroom and the central supply rooms.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure 1 of 1 manual hood fire extinguishing activation devices was located in the path of egress. Section 9.2.3 requires commercial cooking equipment to be in compliance with NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96 at Section 7-5.1 states a readily accessible means for manual activation</p>	K 069	<p>It is the practice of this facility to maintain compliance with this life safety standard, including cooking facilities are protected .</p> <p><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></p> <p>- The activation device in the dietary department was relocated to meet life safety standards.</p> <p>Attachment: M (Allied Safety work</p>	02/27/2015			

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K 144 SS=F Bldg. 01	<p>shall be located between 42 inches and 60 inches above the floor, located in a path of exit or egress, and clearly identify the hazard protected. This deficient practice was not in a resident area but could affect kitchen staff.</p> <p>Findings include:</p> <p>Based on an observation on 02/11/15 at 11:01 a.m., the Maintenance Director and the Regional Director of Facility Management acknowledged the activation device for the kitchen hood fire protection system was mounted on the wall at the back of the kitchen requiring the kitchen staff go behind the bank of cooking equipment in order to activate the hood suppression system.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p>		<p>order)</p> <ul style="list-style-type: none"> - <u>Identification of other residents with potential to be affected by alleged deficient practice:</u> A one-time facility audit was completed to ensure that all pull stations are outside the path of egress. No other issues were found to be out of compliance. - <u>Measures put into place to ensure alleged deficient practice does not recur:</u> Inspection of pull alarm stations have been added to monthly preventative rounds completed by the Maintenance department. - <u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u> The Maintenance Director will inspect any pull stations prior to installation to ensure that they are placed within the fire safety standard. <p>The Administrator will follow-up with visual observation once the job is completed as a final check to ensure compliance with fire safety standard.</p>		

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	<p>1. Based on record review and interview, the facility failed to ensure 2 of 2 emergency generators were exercised a minimum of 30 minutes under load at least monthly. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Preventative Maintenance" generator log on 02/10/15 at 12:15 a.m., the Maintenance Director and the Maintenance Assistant stated and the documentation indicated both emergency generators were exercised under load for 30 minutes without a cool down time.</p> <p>Based on an interview with the Maintenance Director after placing a phone call to the generator maintenance company "H & G", both generators must exercised monthly for an additional 10 to</p>	K 144	<p><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u> - A generator test was completed on 2-27-15. This test was completed under load for 30 minutes and results indicate cooling time per life safety standard. Item 3: The lighting at the south generator was repaired during the survey. Attachment: N(Generator test) <u>Identification of other residents with potential to be affected by alleged deficient practice:</u> All residents have potential to be affected by alleged deficient practice. <u>Measures put into place to ensure alleged deficient practice does not recur:</u> - Extra time was added to the generator test time to cover cool down requirements <u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u> - Results of the generator test will be turned in to the administrator on a monthly basis, who will be responsible to review for compliance. The maintenance director will report status of compliance during the QAPI committee meeting . Any issues identified will be addressed accordingly. System will be reviewed monthly for 3 months, or longer if the team deems necessary. Appropriate lighting will be a added step to the audit tool utilized to</p>	03/13/2015			

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	<p>15 minutes without a load to allow the generators to cool down.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 8 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the generator log titled "Preventative Maintenance" on</p>		<p>document generator testing to ensure that task lighting is functioning. Any areas identified will be corrected immediately</p>	

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	<p>02/10/15 at 12:26 p.m., the Maintenance Director and Maintenance Assistant provided documentation of a generator load test for the months of June thru August of 2014 and January of 2015. Based on an interview at the time of record review, the Maintenance Assistant stated he was the only person assigned to maintenance during the remaining months and therefore recorded all undocumented eight months for the previous year in the June thru August time frame. He was unable to provide any additional documentation.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to provide emergency task lighting in and around 1 of 2 generator sets in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires the EPS (Emergency Power Supply) equipment location shall be provided with battery powered emergency lighting. This deficient practice could affect all occupants supplied power by the</p>			

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K 147 SS=D Bldg. 01	<p>generator located in the South hall.</p> <p>Findings include:</p> <p>Based on an observation and interview on 02/11/15 at 2:32 p.m., the Maintenance Director acknowledged the battery operated emergency task lighting at the South hall emergency generator failed to illuminate when tested.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation, the facility failed to ensure 1 of 1 East hall nurses' station electrical junction boxes observed was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with</p>	K 147	<p>It is the policy of this facility to maintain electrical wiring and equipment in accordance with life safety standards.</p> <p><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></p> <p>1)The electrical receptacle at the East Hall nurses station was repaired.</p> <p>2) The extension cord power strip in</p>	03/13/2015			

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	<p>covers compatible with the box. This deficient practice could affect occupants near the East hall nurses' station.</p> <p>Findings include:</p> <p>Based on observation and interview on 02/11/15 at 2:10 p.m., the Maintenance Director acknowledged the electrical receptacle mounted on the wall in the East hall nurses' station lacked a cover.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, 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 3 to 5 residents in the East hall Activity room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 02/11/15 at 12:58 p.m., a wall mounted air conditioner was plugged in and supplied power by an extension cord power strip</p>		<p>the activity room on East hall was removed.</p> <p>- <u>Identification of other residents with potential to be affected by alleged deficient practice:</u></p> <p>100% house audit completed to check electrical receptacles and to check for extension cord power strips.</p> <p>Attachment P: (Electrical/extension cord audit)</p> <p>- <u>Measures put into place to ensure alleged deficient practice does not recur:</u></p> <p>- Maintenance will complete wkly room rounds on each wing, specifically looking for broken/missing receptacles and extension cords. Any issues found will be addressed and/or removed</p> <p><u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></p> <p>- The Maintenance Director will review wkly round results with the Administrator once a week to identify and correct issues as needed. The maintenance director will also report in QAPI committee the results once a month for three months. If no issues, the tag will be reviewed once each quarter. Letters will be sent out to residents and families to remind them of Life</p>	

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K 154 SS=C Bldg. 01	<p>in in the East hall Activity room. The Maintenance Director acknowledged and removed to power strip at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. in order to protect 147 of 147 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, A-11-5(c)2 states, "a fire watch should consist of trained personnel who continuously patrol the effected area. Ready access to fire extinguishers</p>	K 154	<p>Safety standards regarding the extension cords.</p> <p><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></p> <p>- The Fire protection system Outage plan has been reviewed and updated to include the element that staff assigned to watch will have no other duties during that time.</p> <p>Attachment R (Fire Protection System Policy)</p> <p><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></p> <p>All residents have potential to be affected of alleged deficient practice.</p> <p>- <u>Measures put into place to ensure</u></p>	03/13/2015

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	<p>and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly." This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review of the "Fire Protection/Fire Alarm System Impairment" on 02/10/15 at 12:20 p.m., the Maintenance Director acknowledged the facility's documentation provided for a plan of action when the automatic sprinkler system was out of service for more than four hours in a twenty four hour period was not complete. The procedure did not include all elements required such as, the person conducting the fire watch shall have no other duties during that time. Based on an interview at the exit conference on 02/11/15 at 3:50, the Administrator stated she had been made aware of the fire watch policy lacked the aforementioned information.</p> <p>3.1-19(b)</p>		<p><u>alleged deficient practice does not recur:</u></p> <p>The policy will be available at all nursing stations for staff reference when the fire watches are initiated. All-staff in-service will be conducted to inform staff of the new language.</p> <p>- <u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></p> <p>- The Educator Coordinator will meet with staff involved in a fire watch to discuss their responsibilities during the watch. Any non-compliance will be discussed with the appropriate supervisor of the staff member. The EC will provide a report back to the QAPI regarding any fire watches that occurred during that month for 3 months and then a quarterly report for 3 months. QAPI committee will make recommendations as necessary including disciplinary action for non-compliance.</p>				

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K 155 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 147 of 147 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice affect all occupants.</p>	K 155	<p><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></p> <p>- The Fire Alarm System Impairment Policy been reviewed and updated to include the element that staff assigned to watch will have no other duties during that time.</p> <p>Attachment: Q (Fire Alarm System Impairment Policy)</p> <p><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></p> <p>All residents have potential to be affected of alleged deficient practice.</p> <p>- <u>Measures put into place to ensure alleged deficient practice does not recur:</u></p> <p>The policy will be available at all nursing stations for staff reference when the fire watches are initiated. All-staff in-service will be conducted to inform staff of the new language.</p> <p>-</p>	03/13/2015			

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