STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/24/14 Facility Number: 000478 Provider Number: 155494 AIM Number: 100290430 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, The Waters of Scottsburg was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and in spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms.	K010000	Preparationand/or execution of this plan of correction in general, or this correctiveaction in particular, does not constitute an admission of agreement by thisfacility of the facts alleged or conclusions set forth in this statement ofdeficiencies. The plan of correction andspecific corrective actions are prepared and/or executed in compliance withState and Federal Laws.	

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

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

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	The facility has a capacity of 99 and had a census of 71 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a detached wooden shed, a detached twelve foot by ten foot metal smoking building, and a detached twenty foot by thirty foot metal storage building. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 2 of 2 kitchen service metal rolling doors were held	K010021	K021-NFPA 101 LIFE SAFETY CODE STANDARD It isthe practice of this facility to	08/21/2014

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	open only by a device arranged to automatically close upon activation of the fire alarm system. This deficient practice could affect up to 36 residents, as well as staff and visitors while in the Main Dining Room from the Sapphire Stream and Emerald Brook units. Findings include: Based on observation on 07/24/14 at 1:45 p.m. during a tour of the facility with the Maintenance Director, the two metal rolling service doors between the kitchen and Main Dining Room were held open with chains and fusible links which would not allow the door to close automatically when the fire alarm system is activated. Based on interview at the time of observation, the Maintenance Director acknowledged the two metal roller doors between the kitchen and Main Dining Room were held open with chains and fusible links which would not allow the doors to close automatically when the fire alarm system was activated. This was further acknowledged at 3:15 p.m. during the fire alarm system test. 3.1-19(b)		comply with all fire safety codes and precautions. We maintain automated closing devices ondoors and passages when the fire alarm is triggered manually or automatically. *What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?* The two rollingservice doors in the kitchen have been tied to the fire alarms system. New FireProof Rolling shutters have been purchased with a tentative installation dateof 9/15/2014. *How will other residents havingthe potential to be affected by the same deficient practice will be identifiedand what corrective actions will be taken?* Allresidents had the potential to be affected. The tworolling service doors in the kitchen have been tied to the fire alarmssystem. New FireProof Rolling shutters have been purchased with a tentative installation dateof 9/15/2014. *What measures or what systemicchanges will be made to ensure that the deficient practice does notreoccur?* Monthlyinspections of proper operation will be performed by the Maintenance Supervisor/ designee once the new shutters are installed. *How the corrective action(s) willbe monitored to ensure the*	

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			deficient practice will not recur, i.e. what qualityassurance program will be put into place? Theadministrator will review the monthly inspection reports associated with ourfire drills to identify any areas of poor function or maintenance. Thesemeasures will be reviewed and adjusted accordingly based on monthly andquarterly QA meetings.	
K010025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4			
	Based on observation and interview, the facility failed to ensure 1 of 7 smoke barrier walls provided at least a one half hour fire resistance rating. This deficient practice could affect up to 12 residents, as well as staff and visitors in the Ruby Bay unit. Findings include: Based on observation on 07/24/14 at 2:40 p.m. during a tour of the facility with the	K010025	K025-NFPA 101 LIFE SAFETY CODE STANDARD It isthe practice of this facility to comply with all fire safety codes andprecautions. We ensure all smoke barrierwalls provide at minimum, a half hour fire resistance rating. *What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?* The ½inch open penetration surrounding a water line between Ruby Bay and the nurses'station	08/21/2014

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	Maintenance Director, the smoke barrier wall above the smoke barrier doors between the Ruby Bay unit and the Main Nurses' Station area had a one half inch open penetration through the wall around a red water drain line. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)		was caulked and sealed with fire rated caulking. *How will other residents havingthe potential to be affected by the same deficient practice will be identifiedand what corrective actions will be taken?* Anassessment was performed by the Maintenance Supervisor and no other residentswere found to potentially be affected. The ½inch open penetration surrounding a water line between Ruby Bay and the nurses'station was caulked and sealed with fire rated caulking. *What measures or what systemicchanges will be made to ensure that the deficient practice does notreoccur?* Wheneveroutside contractors are required to be up in the attic performing labor, uponthe completion of their services, the maintenance director / designee shallperform a visual inspection of the area where the work was performed and makerepairs as needed. Theseresults of these inspections will be provided to the administrator for review. *How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance program will be put into place?* Wheneveroutside contractors are required to be up in the attic performing labor, uponthe completion of their services, the maintenance director / designee	

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			shallperform a visual inspection of the area where the work was performed and makerepairs as needed. Theseresults of these inspections will be provided to the administrator for review. Thesemeasures will be reviewed and adjusted accordingly based on monthly andquarterly QA meetings.	
K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1			
	1. Based on observation and interview, the facility failed to ensure 1 of 2 shower rooms which contained soiled linen and trash containers over 32 gallons in capacity, was equipped with a self closing device on the door. This deficient practice could affect up to 22 residents, as well as staff and visitors in the Sapphire Stream unit. Findings include:	K010029	K029-NFPA 101 LIFE SAFETY CODE STANDARD It isthe practice of this facility to comply with all fire safety codes andprecautions. We ensure all requireddoors have a self-closing device installed and functional. *What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?* Theshower door on Sapphire Hall had a self-closing device installed. Thestorage room door on	08/21/2014

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	Based on observation on 07/24/14 at 1:25 p.m. during a tour of the facility with the Maintenance Director, the Sapphire Stream unit shower room door was not equipped with a self closing device. This shower room contained one rubber barrel and two bins over 32 gallons in size each half to full of soiled linen and trash. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 12 hazardous area room doors, such as a room over 50 square feet containing combustible material, was equipped with a self closing device on the door. This deficient practice could affect up to 14 residents, as well as staff and visitors in the Emerald Brook unit. Findings include: Based on observation on 07/24/14 at 2:10 p.m. during a tour of the facility with the Maintenance Director, room 121 in the Emerald Brook unit, a hazardous area room over 50 square feet containing a large amount of combustible material such as cardboard boxes, furniture, beds, mattresses, and other items, was not provided with a self closing device on the		Emerald Brook had a self-closing device installed. *How will other residents havingthe potential to be affected by the same deficient practice will be identifiedand what corrective actions will be taken?* Anassessment was performed by the Maintenance Supervisor and no other residentswere found to potentially be affected. Theshower door on Sapphire Hall had a self-closing device installed. Thestorage room door on Emerald Brook had a self-closing device installed. A 100%audit was performed on all doors to ensure they have the required self-closinghardware. *What measures or what systemicchanges will be made to ensure that the deficient practice does notreoccur?* A 100%audit was performed on all doors to ensure they have the required self-closinghardware. Uponidentification of door replacement, the maintenance director / designee shallinspect the final steps of installation to ensure any required self-closingdevice has been installed. Theseresults of these inspections will be provided to the administrator for review. *How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance program will be put into place?*	

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	door. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)		Uponidentification of door replacement, the maintenance director shall inspect thefinal steps of installation to ensure any required self-closing device has beeninstalled. Theseresults of these inspections will be provided to the administrator for review. Thesemeasures will be reviewed and adjusted accordingly based on monthly andquarterly QA meetings.	
K010046 SS=C	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. Based on record review, observation, and interview; the facility failed to ensure 1 of 1 battery powered light sets was tested monthly for 30 seconds and annually for 90 minutes. LSC 101, Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall	K010046	K046-NFPA 101 LIFE SAFETY CODE STANDARD It isthe practice of this facility to comply with all fire safety codes andprecautions. This facility ensures thatall backup lighting is functional and has been inspected per regulations. *What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?* Thebackup light located above the generator was replaced and tested to run 30seconds for the monthly inspection test, and then again for 90 minutes to satisfythe annual inspection requirement. *How will other residents havingthe potential to be affected by the same deficient practice will be identifiedand what corrective actions will be taken?*	08/21/2014

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	be provided with battery powered emergency lighting. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the Fire Book on 07/24/14 between 10:00 a.m. and 1:00 p.m. with the Maintenance Director present, there was no documentation to show the battery back up light set over the generator was tested monthly, plus, there was no documentation to show the battery back up light set was tested for ninety minutes annually within the past twelve months. Furthermore, based on observation at 3:00 p.m. during a tour of the facility with the Maintenance Director, the battery back up light set over the generator did not work when tested. This was confirmed by Maintenance Director at the time of record review and observation. 3-1.19(b)		Anassessment was performed by the Maintenance Supervisor and no other residentswere found to potentially be affected. Thebackup light located above the generator was replaced and tested to run 30seconds for the monthly inspection test, and then again for 90 minutes to satisfythe annual inspection requirement. A 100%audit was performed on all emergency lighting to ensure they have had theproper inspections, and are in fact, operating properly.. *What measures or what systemicchanges will be made to ensure that the deficient practice does notreoccur?* A 100%audit was performed on all emergency lighting to ensure they have had theproper inspections, and are in fact, operating properly.. Monthlyinspections of emergency lighting will be performed by the maintenancesupervisor. The resultsof these inspections will be provided to the administrator for review. *How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance program will be put into place?* A 100%audit was performed on all emergency lighting to ensure they have had theproper inspections, and are in fact, operating properly.. Monthlyinspections of emergency lighting will be performed by the	

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			maintenancesupervisor. The resultsof these inspections will be provided to the administrator for review. Thesemeasures will be reviewed and adjusted accordingly based on monthly andquarterly QA meetings.	
K010048 SS=F	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 complete written fire safety plan for the protection of 71 of 71 residents to accurately address all life safety systems such as staff response to battery operated or single station smoke detectors in resident sleeping rooms, plus a system addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (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	K010048	K048-NFPA 101 LIFE SAFETY CODE STANDARD It isthe practice of this facility to comply with all fire safety codes andprecautions. This facility ensures thatwe maintain a complete and accurate fire plan. *What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?* The FirePlan was updated to include the procedures for staff to complete when a batteryoperated smoke alarm begins to make noise. The FirePlan was also updated to ensure that all actions address all fires, and anyverbiage pertaining to the size of a fire has been removed. Staffwas re-inserviced on the proper procedures and actions in the event of a fire,including being provided a copy of the updated Fire Plan. *How will other residents havingthe potential to be affected by the same deficient practice will be identifiedand what*	08/21/2014

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	This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the Fire Plan in the Disaster Plan on 07/24/14 between 11:50 a.m. and 12:15 p.m. with the Maintenance Director present, the Fire Plan did not address staff response to battery operated smoke detectors in resident sleeping rooms. Furthermore, R.A.C.E. was addressed and the "C" for Confine stated "If fire is small and controllable, attempt to extinguish fire by covering, smothering, eliminating fuel source, etc." Based on interview at the time of record review, the Maintenance Director acknowledged the Fire Plan was not a complete and accurate plan. 3.1-19(b)		*corrective actions will be taken?* All residentshad the potential to be affected. The FirePlan was updated to include the procedures for staff to complete when a batteryoperated smoke alarm begins to make noise. The FirePlan was also updated to ensure that all actions address all fires, and anyverbiage pertaining to the size of a fire has been removed. Staffwas re-inserviced on the proper procedures and actions in the event of a fire,including being provided a copy of the updated Fire Plan. *What measures or what systemicchanges will be made to ensure that the deficient practice does notreoccur?* The FirePlan was updated to include the procedures for staff to complete when a batteryoperated smoke alarm begins to make noise. The FirePlan was also updated to ensure that all actions address all fires, and anyverbiage pertaining to the size of a fire has been removed. Staffwas re-inserviced on the proper procedures and actions in the event of a fire,including being provided a copy of the updated Fire Plan. *How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance program will be put into place?* Theupdated Fire Plan will be inserviced to staff regularly though-out the year,and thereafter. The Maintenance	

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			Director/ designee will ensure this information is available and posted whereappropriate. Ongoing monthly reviews ofthis material will be performed by the Maintenance Director / designee. The results of these reviews will bedelivered to the QA&A Committee. Thesemeasures will be reviewed and adjusted accordingly based on monthly andquarterly QA meetings.	
K010052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to ensure 9 of 20 smoke detectors that had been tested and failed sensitivity testing were replaced. NFPA 72, National Fire Alarm Code, 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 may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be	K010052	K052-NFPA 101 LIFE SAFETY CODE STANDARD It isthe practice of this facility to comply with all fire safety codes andprecautions. This facility ensures wemaintain smoke detectors with documented sensitivity tests, and the correctiveactions completed if there were any detectors that failed the sensitivitytests. *What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?* The 9smoke detectors in question have been replaced to ensure that they arefunctional and pass sensitivity tests. Sensitivitytest schedule was	08/21/2014

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	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: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (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. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced." 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 shall be the responsibility of the owner to maintain these records for the life of the system and to keep them available for		developed by the maintenance director to maintain thebi-annual sensitivity tests. *How will other residents havingthe potential to be affected by the same deficient practice will be identifiedand what corrective actions will be taken?* Allresidents had the potential to be affected. The 9smoke detectors in question have been replaced to ensure that they arefunctional and pass sensitivity tests. Sensitivitytest schedule was developed by the maintenance director to maintain thebi-annual sensitivity tests. *What measures or what systemicchanges will be made to ensure that the deficient practice does notreoccur?* The 9smoke detectors in question have been replaced to ensure that they arefunctional and pass sensitivity tests. Sensitivitytest schedule was developed by the maintenance director to maintain thebi-annual sensitivity tests. *How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance program will be put into place?* Thesensitivity test schedule has been provided to the administrator for review. Results of those tests will be delivered tothe Administrator upon completion. Theresults of those tests will also be delivered to the	

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	examination by the authority having jurisdiction. Paper or electronic media shall be acceptable. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the smoke detector sensitivity records in the Fire Book on 07/24/14 at 12:10 p.m. with the Maintenance Director present, the most recent sensitivity test documentation available was dated 02/14/13 for twenty smoke detectors where nine smoke detectors failed the sensitivity test. The facility was not able to produce documentation to show if the nine smoke detectors were replaced and if retesting for sensitivity was performed. Based on interview at the time of record review, the Maintenance Director stated the nine smoke detectors have not been replaced. 3.1-19(b)		QA&A Committee. Thesemeasures will be reviewed and adjusted accordingly based on monthly andquarterly QA meetings.	
K010062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on record review, observation and interview; the facility failed to ensure	K010062	K062-NFPA 101 LIFE SAFETY CODE STANDARD	08/21/2014

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	2 of 2 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected and the necessary corrective action shall be taken. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the preventive maintenance records in the Fire Book on 07/24/14 at 10:45 a.m. with the Maintenance Director present, there was no documentation to show the facility's two fire hydrants have had an annual inspection during the past twelve months. The most recent fire hydrant inspection report was dated 05/16/13. Based on interview at the time of record review, the Maintenance Director confirmed there was no documentation available to show the facility's two fire hydrants have been inspected during the past twelve months. Based on observation on 07/24/14 between 12:45 p.m. and 3:15 p.m. during a tour of the facility with the		It isthe practice of this facility to comply with all fire safety codes andprecautions. This facility ensures wemaintain and inspect any private fire hydrants annually, and maintains thedocumentation. This facility alsoensures that all sprinkler heads are free from corrosion, or any potentialwater flow obstructions. *What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?* The twoprivate fire hydrants have been inspected, and have been scheduled to beinspected again in approximately 9 months' time. The 4sprinkler heads that had some corrosion were cleaned thoroughly. *How will other residents havingthe potential to be affected by the same deficient practice will be identifiedand what corrective actions will be taken?* Anassessment was performed by the Maintenance Supervisor and no other residentswere found to potentially be affected. The twoprivate fire hydrants have been inspected, and have been scheduled to be inspectedagain in approximately 9 months' time. The 4sprinkler heads that had some corrosion were cleaned thoroughly. *What measures or what systemicchanges will be made to ensure that the deficient practice does notreoccur?* The twoprivate fire hydrants have	

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	Maintenance Director, there were two private fire hydrants on the facility's property. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 4 of over 500 sprinkler heads in the facility were free of corrosion. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be free of paint and corrosion. Any sprinkler shall be replaced that is painted or corroded. This deficient practice could affect mostly laundry staff, plus up to 36 residents, as well as staff and visitors while in the Main Dining Room which was in the same smoke compartment as the laundry room. Findings include: Based on observation on 07/24/14 at 2:00 p.m. during a tour of the facility with the Maintenance Director, there were four sprinkler heads in the laundry room covered with green corrosion. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)		been inspected, and have been scheduled to be inspectedagain in approximately 9 months' time. The 4sprinkler heads that had some corrosion were cleaned thoroughly. Monthly visualinspections will be performed by the maintenance director. *How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance program will be put into place?* The twoprivate fire hydrants have been inspected, and have been scheduled to beinspected again in approximately 9 months' time. The 4sprinkler heads that had some corrosion were cleaned thoroughly. Monthlyvisual inspections will commence by the maintenance director, and results willbe provided to the administrator for review. Thesemeasures will be reviewed and adjusted accordingly based on monthly andquarterly QA meetings.	

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K010069 SS=A	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen range hood's fire extinguishing equipment was inspected and approved every 6 months by properly trained and qualified persons, furthermore, the facility failed to ensure all components of the range hood fire extinguishing system were in proper operating condition. LSC 9.2.3 refers to NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, in 8-2 requires the inspection and servicing of the fire extinguishing system and listed exhaust hoods containing a constant or fire actuated water system shall be made at least every 6 months by properly trained and qualified persons. NFPA 96, 8-2.1 requires all actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, and fire actuated dampers shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice could affect mostly kitchen staff.	K010069	K069-NFPA 101 LIFE SAFETY CODE STANDARD It isthe practice of this facility to comply with all fire safety codes andprecautions. This facility ensures allfire extinguishing equipment on the premises has had the required inspectionand approval. *What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?* Thekitchen's fire hood had an inspection performed of its' fire extinguishingequipment. A 6month inspection schedule was put together with our vendor that performs theseinspections. *How will other residents havingthe potential to be affected by the same deficient practice will be identifiedand what corrective actions will be taken?* Anassessment was performed by the Maintenance Supervisor and no other residentswere found to potentially be affected. Thekitchen's fire hood had an inspection performed of its' fire extinguishingequipment. A 6month inspection schedule was put together with our vendor that performs theseinspections. *What measures or what systemicchanges will be made to*	08/21/2014

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	Findings include: Based on review of the range hood inspection reports in the Fire Book on 07/24/14 at 11:00 a.m. with the Maintenance Director present, there was no documentation to show the kitchen range hood's fire extinguishing equipment was inspected every six months. The only range hood fire extinguishing equipment inspection report was dated 06/16/14 during the past twelve months. This was acknowledged by the Maintenance Director at the time of record review. 3.1-19(b)		*ensure that the deficient practice does notreoccur?* Thekitchen's fire hood had an inspection performed of its' fire extinguishingequipment. A 6month inspection schedule was put together with our vendor that performs theseinspections. *How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance program will be put into place?* Thekitchen's fire hood had an inspection performed of its' fire extinguishingequipment. A 6month inspection schedule was put together with our vendor that performs theseinspections. Theinspection schedule will be provided to the administrator on a monthly basisfor review. The Maintenance Director /designee will monitor the inspection schedule to ensure the inspections areperformed as planned. Thesemeasures will be reviewed and adjusted accordingly based on monthly and quarterlyQA meetings.	
K010075 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater			

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	than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for mobile soiled linen or trash collection receptacles was not exceeded within any 64 square foot area in 3 of 4 resident room corridors. This deficient practice could affect up to 49 residents, as well as staff and visitors in the Ruby Bay, Emerald Brook, and Onyx Cove units. Findings include: Based on observations on 07/24/14 between 12:45 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. One 32 gallon barrel and two bins each at least half full of trash and soiled linens, were stored next to each other in the Onyx Cove unit outside room 149. b. One 32 gallon barrel and two bins each at least half full of trash and soiled linens, were stored next to each other in the Emerald Brook unit outside room 111. c. One 32 gallon barrel and two bins each at least half full of trash and soiled linens, were stored next to each other in the Ruby Bay unit outside room 105. This was acknowledged by the	K010075	K075-NFPA 101 LIFE SAFETY CODE STANDARD It isthe practice of this facility to comply with all fire safety codes andprecautions. This facility ensures thereare no containers in any room or area that exceeds 32 gallons within a 64 Sq/Ftarea, and that no 32 gallon containers are stored in any resident rooms. *What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?* The 32gallon trash receptacles will be maintained in a common, appropriate areaseparate from the linen receptacles. None ofthese receptacles will be stored in any resident rooms, nor will they be storedtogether. *How will other residents havingthe potential to be affected by the same deficient practice will be identifiedand what corrective actions will be taken?* All residenthave the potential to be affected. The 32gallon trash receptacles will be maintained in a common, appropriate areaseparate from the linen receptacles. None ofthese receptacles will be stored in any resident rooms, nor will they be storedtogether. *What measures or what systemicchanges will be made to ensure that the deficient practice does notreoccur?*	08/21/2014

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	Maintenance Director at the time of each observation, furthermore, when asked, the Maintenance Director said the soiled linen and trash barrels and bins were normally stored in the corridors even when not in use. 3.1-19(b)		Thehousekeeping supervisor will conduct audits 3 times a week for 3 weeks toensure the containers are being stored in the appropriate areas. *How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance program will be put into place?* Thehousekeeping supervisor will conduct audits 3 times a week for 3 weeks toensure the containers are being stored in the appropriate areas. Theresults of these audits will be provided to the administrator for review on aweekly basis. Thesemeasures will be reviewed and adjusted accordingly based on monthly andquarterly QA meetings.	
K010130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the care and maintenance of 2 of 2 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding	K010130	K130-NFPA 101 LIFE SAFETY CODE STANDARD It isthe practice of this facility to comply with all fire safety codes andprecautions. This facility ensures allfunctionality inspections have been performed at the appropriate frequency. *What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?* New FireShutter Doors have been purchased and are tentatively scheduled to be installed9/4/2014. At this	08/21/2014

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	and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect up to 36 residents, as well as staff and visitors while in the Main Dining Room from the Sapphire Stream and Emerald Brook units. Findings include: Based on observation on 07/24/14 at 1:45 p.m. during a tour of the facility with the Maintenance Director, the two metal rolling fire doors were without current inspection tags protecting the openings from the kitchen to the Main Dining Room. The most recent tags/stickers on the two metal rolling fire doors were dated 12/12. Based on interview at the time of observation, this was confirmed by the Maintenance Director, furthermore, the Maintenance Director stated there was no additional documentation of an annual inspection or test for the two kitchen rolling fire doors to check for proper operation and full closure of the metal curtain since the 12/12 inspection.		juncture, theinstallation company will set an annual inspection and maintenance schedulewith the maintenance director. *How will other residents havingthe potential to be affected by the same deficient practice will be identifiedand what corrective actions will be taken?* Anassessment was performed by the Maintenance Supervisor and no other residentswere found to potentially be affected. New FireShutter Doors have been purchased and are tentatively scheduled to be installed9/4/2014. At this juncture, theinstallation company will set an annual inspection and maintenance schedulewith the maintenance director. *What measures or what systemicchanges will be made to ensure that the deficient practice does notreoccur?* New FireShutter Doors have been purchased and are tentatively scheduled to be installed9/4/2014. At this juncture, theinstallation company will set an annual inspection and maintenance schedulewith the maintenance director. *How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance program will be put into place?* Themaintenance supervisor will add this inspection date to his inspectionschedule, and provide copies to the administrator for	

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	3.1-19(b)		review monthly. Thesemeasures will be reviewed and adjusted accordingly based on monthly andquarterly QA meetings.	
K010144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review, observation and interview; the facility failed to ensure the off site fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110, 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid Petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on site storage of an alternate energy source sufficient to allow full output of the emergency power	K010144	K144-NFPA 101 LIFE SAFETY CODE STANDARD It isthe practice of this facility to comply with all fire safety codes andprecautions. This facility ensures thatin the case of a natural disaster or emergency, we are prioritized for ourgenerator fuel needs from an off-site provider. *What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?* A letter was obtained from Midwest Natural GasCorporation, ensuring that as a Skilled Nursing Facility, we will be givenpriority and provided fuel for generator needs as long as logisticallypossible. *How will other residents havingthe potential to be affected by the same deficient practice will be identified andwhat corrective actions will be taken?* Allresidents could be affected. A letterwas obtained from Midwest Natural Gas Corporation, ensuring that as a SkilledNursing	08/21/2014

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	supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. CMS requires evidence of reliability of the natural fuel source must contain all of the following: a. A statement of reasonable reliability of the natural gas delivery; b. A brief description the supports the statement regarding the reliability; c. A statement there is a low probability of interruption of the natural gas; d. A brief description that supports the statement regarding the low probability of interruption; e. The signature of technical personnel from the natural gas vendor. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator log in the Fire Book on 07/24/14 between 10:00 a.m. and 1:00 p.m. with the Maintenance Director present, it was determined the emergency generator was a natural gas generator with no on site fuel available. During an interview at 12:25 p.m. the Maintenance Director said the facility did not have a letter from their natural gas		Facility, we will be given priority and provided fuel for generatorneeds as long as logistically possible. *What measures or what systemicchanges will be made to ensure that the deficient practice does notreoccur?* A letterwas obtained from Midwest Natural Gas Corporation, ensuring that as a SkilledNursing Facility, we will be given priority and provided fuel for generatorneeds as long as logistically possible. *How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance program will be put into place?* A letterwas obtained from Midwest Natural Gas Corporation, ensuring that as a SkilledNursing Facility, we will be given priority and provided fuel for generatorneeds as long as logistically possible. TheMaintenance Director / designee will review the arrangement with MidwestNatural Gas annually to ensure its successful status. Thesemeasures will be reviewed and adjusted accordingly based on monthly andquarterly QA meetings.	

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	provider as evidence of reliability of their natural gas supply. Based on observation at 3:00 p.m. during a tour of the facility with the Maintenance Director, the generator in the generator housing unit was powered with natural gas only. 3.1-19(b)			