

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2016
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NAME OF PROVIDER OR SUPPLIER ALPHA HOME - A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN 46222
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K 0000 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 Date: 08/23/16</p> <p>Facility Number: 000376 Provider Number: 155717 AIM Number: 100275510</p> <p>At this Life Safety Code survey, Alpha Home - A Waters Community 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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 86 and had</p>	K 0000	This response to the 2567 issued after the facility's survey is to serve as a plan of correction for the tags cited within. This plan of correction is not to serve as an admission of guilt by the facility or its owner.	
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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 0021 SS=E Bldg. 01	<p>a census of 31 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one detached storage shed.</p> <p>Quality Review completed on 08/29/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (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 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2</p> <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. Based on observation and interview, the facility failed to ensure 2 of 3 attic access</p>	K 0021	<p>i. The attic doors were closed and will remain closed to ensure that smoke barrier is in tact at all</p>	09/22/2016			

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K 0025	<p>doors in the ceiling smoke barrier were held open only by a device arranged to automatically close the door upon activation of the fire alarm system. This deficient practice could affect 16 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:10 p.m. on 08/23/16, the 90 minute fire rated attic access door in the ceiling smoke barrier of the transfer switch room and in the 300 Hall nurses storage room ceiling smoke barrier were each in the fully open position, were not self closing and were not arranged to automatically close the door upon activation of the fire alarm system. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned attic access doors were left in the fully open position, were not self-closing and were not were held open only by a device arranged to automatically close the door upon activation of the fire alarm system.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		<p>times. II. Residents that reside in the facility have the potential to be affected. III. All attic doors will be closed and laminated sign will be placed on on outside of door reminding staff to keep door closed at all times. Maintenance director and/or designee has been educated to ensure that he keeps door closed when not going into the attic. Failure to comply with the points of the in-service will result in further education and/or progressive discipline as needed. IV. The administrator or his designee will perform random audits to ensure that the attic doors are closed 3 times per week until 4 consecutive weeks of no negative findings are achieved. After that, monitoring will occur weekly for not less than 6 months to ensure ongoing compliance. Ongoing random monitoring will continue after that. Results of monitoring will be reviewed at the monthly QA meetings. Any concerns will have been corrected as discovered, however, any patterns will be identified and an action plan will be written by the committee as indicated. Any action plan will be monitored by the administrator or his designee until resolved. V. The corrective practice will be effective by 9-22-16.</p>		

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SS=E Bldg. 01	<p>LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames.</p> <p>8.3, 19.3.7.3, 19.3.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 10 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that 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 30 residents, staff and visitors in the vicinity of the 200 Hall smoke barrier door set.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:10 p.m. on 08/23/16, a one inch in diameter open ended conduit for the passage of one cable and a three inch hole for the</p>	K 0025	<p>I. The facility will ensure that the smoke barrier wall described in the 2567 is protected to maintain the smoke resistance of the smoke barrier. The one inch conduit was sealed was fire stopped. The three inch hole in the electrical room was also fire stopped. II. The maintenance director inspected the facility to ensure that no other openings were present. III. This deficiency has the potential to affect the residents who reside within and other visitors to the facility. IV. The maintenance director has been in-serviced ton this requirement. Failure to comply with the points of the in-servicing will result in further education and/or progressive discipline as indicated. The results of the monitoring will be reviewed at the monthly QA meetings. Any concerns will have been corrected as discovered, however any patterns will be identified and an action plan will be written by the committee as indicated. The administrator or his designee will monitor any action plan weekly until</p>	09/22/2016

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	<p>passage of ten cables were noted in the smoke barrier wall above the suspended ceiling at the 200 Hall corridor door set which were not firestopped. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned holes in the 200 Hall smoke barrier wall did not ensure the smoke barrier wall was protected to maintain the smoke resistance of the smoke barrier.</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 protected to maintain at least a one half hour fire resistance rating. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that 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. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that</p>		<p>resolution. V. The deficient practice will be in compliance on 9-22-16.</p>	

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	<p>is designed for the specific purpose. This deficient practice could affect 30 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:10 p.m. on 08/23/16, the following openings were noted in the ceiling smoke barrier which were not filled with a material capable of maintaining the smoke resistance of the smoke barrier:</p> <p>a. a three inch in diameter hole in the electrical room containing the facility's automatic sprinkler system riser by the north wall.</p> <p>b. a one inch by six inch hole for the passage of 28 cables in the electrical room by Room 309.</p> <p>Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned openings in the ceiling smoke barrier were not filled with a material capable of maintaining the smoke resistance of the ceiling smoke barrier.</p> <p>3.1-19(b)</p>			

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K 0029 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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>Based on observation and interview, the facility failed to ensure 1 of 10 hazardous areas such as combustible storage rooms over 50 square feet were separated from other spaces by smoke resistant partitions. This deficient practice could affect 30 residents, staff and visitors in the vicinity of the electrical room containing the facility's automatic sprinkler system riser.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:10 p.m. on 08/23/16, the following openings were noted in the electrical room containing the facility's automatic sprinkler system</p>	K 0029	<p>I. The facility removed all the combustible boxes and supplies. The three inch hole in the north wall was filled with fire rated barrier caulk. The six inch by eight inch hole was repaired so that a smoke resistant partition was in place. II. An audit was conducted and it was determined that no other residents outside of the 30 mentioned in the 2567 could be affected. III. Maintenance and housekeeping staff were educated to ensure that no other combustible materials could go into the facility's riser room. IV. The administrator or his designee will perform random audits to ensure that materials previously mentioned are not being stored in the space. The administrator or his designee will perform random audits weekly until 4 consecutive</p>	09/22/2016

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K 0038 SS=E Bldg. 01	<p>riser which measured greater than fifty square feet in size and was used for storage of combustible boxes and supplies:</p> <p>a. a three inch in diameter hole was noted in the ceiling by the north wall.</p> <p>b. a six inch by eight inch square hole for the passage of eight one inch in diameter conduits which penetrated the north wall.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned holes in the electrical room did not separate this hazardous area from other spaces with smoke resistant partitions.</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>Based on observation and interview, the facility failed to ensure the means of egress through 2 of 6 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states</p>	K 0038	<p>weeks of zero negative findings is achieved. After that, monitoring will occur weekly ongoing.</p> <p>Afterwards, weekly monitoring will occur ongoing. Any concerns will be corrected as found.</p> <p>Information about the results of the monitoring being reviewed monthly at the QA meeting and any patterns are identified will have an action plan written and that administrator will monitor any written action weekly until a resolution is reached. V. The facility will be in compliance no later than 9-2-16.</p> <p>I. The facility posted the exit code to ensure that the code to exit the facility via the locations mentioned in the 2567 were posted at those locations. II. The maintenance director will check facility's exits to determine which ones need to have the code posted. Any persons needing the code received it. III. The maintenance director was in-serviced on ensuring that the</p>	09/22/2016

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	<p>door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 30 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:10 p.m. on 08/23/16, the exit door from the 300 Hall and the Housekeeping exit door by the Pantry were each marked as a facility exit and each exit door was magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of the observations, the Maintenance Director stated residents who have a clinical diagnosis to be in a secure building reside in the Alzheimer's Wing in the 200 Hall and acknowledged the four digit code was not posted at the aforementioned two exit doors. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.</p>		<p>exit code is posted by the facility's exits. Further instances of the code not being posted will result in further education and/or disciplinary action. The maintenance director will ensure that the code to exit the facility remains posted indefinitely to ensure that the public and residents are able to exit the facility. IV. The administrator or his designee will perform random audits 3 days per week until 4 consecutive weeks of zero negative findings is achieved. A weekly check will then be ongoing. The results of the audit will be reviewed in the monthly QA meeting. Any patterns will be identified and an action plan will be written to address the pattern. Action will be followed until issue is resolved. V. Steps to correct the deficient practice will be in place by 9-22-16.</p>	

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K 0046 SS=C Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.</p> <p>Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 1 of 1 battery powered lights for the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 1/2 -hr duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:20 a.m. to</p>	K 0046	<p>I. A form was implemented to monitor the monthly testing for not less than 30 seconds of the emergency light. II. The deficient practice has the potential to affect all of the residents within the facility. III. The maintenance director will be reeducated on how to use the monitoring tool. Any failure to comply with the points of the in-service will result in further education and/or progressive discipline. IV. The administrator or his designee will perform random audits weekly until 4 consecutive weeks of zero negative findings then weekly ongoing. Results of the audits will be addressed in the monthly QA meeting. If patterns are identified an action plan will be written. V. The facility will be in compliance by 9-22-16.</p>	09/22/2016	

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	<p>11:20 a.m. on 08/23/16, documentation of monthly functional testing and annual testing for not less than 1 ½ -hr duration for facility battery powered emergency lights for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility has one battery powered emergency light at the emergency generator location. Based on observation with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:10 p.m. on 08/23/16, one facility battery powered light was located in the facility at the emergency generator location which illuminated when its respective test button was pushed. Based on interview at the time of record review and of the observation, the Maintenance Director acknowledged documentation of monthly functional testing and annual testing for not less than 1 ½ -hr duration for the most recent twelve month period for the battery powered emergency light located at the emergency generator was not available for review.</p> <p>3.1-19(b)</p>			

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K 0050 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>1. Based on record review and interview, the facility failed to document fire drills conducted on the first, second and third shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Maintenance Director during record review from 9:20 a.m. to 11:20 a.m. on 08/23/16, documentation of a fire drill conducted on the first, second and third shift in the first quarter (January, February, March) 2016 was not available for review. Based on interview at the time of record review, the Maintenance Director stated no additional fire drill documentation was available for review and acknowledged</p>	K 0050	<p>I. The facility will conduct fire drills at unexpected times. The facility will also keep documentation of the dates and times of the drills conducted. II. This deficient practice has the potential to affect all residents, staff and visitors of the facility. III. The maintenance staff will be inserviced on the fire drill requirements. The Maintenance director will schedule all fire drills with the administrator of his designee to ensure that the are at unexpected times for the staff. IV. The administrator or his designee will perform random audits twice monthly for 6 months and then monthly ongoing. The reviews of the fire drills will be addressed at the monthly QA meeting. V. The facility will be out of deficient practice on 9-22-16.</p>	09/22/2016			

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	<p>documentation of a fire drill conducted on the first, second and third shift in the first quarter 2016 was not available for review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to document activation of the fire alarm system for fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Maintenance Director during record review from 9:20 a.m. to 11:20 a.m. on 08/23/16, documentation for the first shift fire drill conducted on 05/25/16 at 2:15 p.m. and documentation for the second shift fire</p>			

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K 0052 SS=F Bldg. 01	<p>drill conducted on 06/22/16 at 7:40 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal. Documentation for the aforementioned first and second shift fire drills stated "No" in response to "Was the alarm activated" and "Did monitoring company receive all signals and alarms". Based on interview at the time of record review, the Maintenance Director acknowledged documentation for the aforementioned fire drills conducted after 6:00 a.m. but before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal.</p> <p>3.1-19(b) 3.1-51(ac)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable</p>	K 0052	<p>I. The facility will fire systems are tested according to NFPA standards and an accurate record will be kept documenting such.</p> <p>II. This deficient practice has the potential to affect all residents,</p>	09/22/2016

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	<p>requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm initiating devices, alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:20 a.m. to 11:20 a.m. on 08/23/16, fire alarm system testing documentation within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged fire alarm system testing documentation within the most recent twelve month period was not available for review.</p> <p>3.1-19(a)</p> <p>2. Based on record review and interview, the facility failed to ensure all smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code.</p>		<p>staff and visitors of the facility.</p> <p>III. The maintenance director has been in-serviced and further education and/or progressive discipline will be administered as necessary. The Maintenance director will ensure that all documentation of calibration and sensitivity tests will be obtained and kept in the appropriate binder for review. IV. The administrator or his designee will perform random audits weekly until 4 consecutive weeks of zero negative findings is achieved. The facility will review the results of the audits during the monthly QA meeting. If a pattern is identified an action will be written. V. The facility will be out of deficient practice on 9-22-16.</p>	

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	<p>NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked); the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (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 listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority 			

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K 0056 SS=E Bldg. 01	<p>having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:20 a.m. to 11:20 a.m. on 08/23/16, documentation of smoke detector sensitivity testing within the most recent two year period was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged sensitivity testing documentation for facility fire alarm system smoke detectors within the most recent two year period was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section</p>			

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	<p>9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>Based on observation and interview, the facility failed to ensure the sprinkler system was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 5-5.4.2 states deflectors of sprinklers shall be aligned parallel to ceilings, roofs, or the incline of stairs. For pendent sprinkler locations, Section 5-6.4.1.1 states the distance between the sprinkler deflector and the ceiling shall be a minimum of one inch and a maximum of twelve inches for unobstructed construction. This deficient practice could affect 15 residents, staff and visitors in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on review of SafeCare's "Service Notes" documentation dated 08/19/16 during record review with the Maintenance Director from 9:20 a.m. to 11:20 a.m. on 08/23/16, six sprinkler head locations were identified as being improperly aligned or too high or low on</p>	K 0056	<p>I. The facility ensure that sprinkler heads will be adjusted and any other adjustments will be made. II. The maintenance director will perform an inspection to ensure that all sprinkler heads beyond the ones mentioned in the 2567 are in proper alignment. III. The deficient practice has the potential to affect 15 residents, staff and visitors in the dining room. IV. The maintenance director will inspect the sprinkler heads monthly to ensure that remain in tact. Documentation of inspections will be kept by the facility. The maintenance director will review the results of the inspections with the administrator or his designee monthly. The maintenance director was in-serviced and further in-servicing and/or progressive discipline will be conducted as necessary. The monitoring results will be discussed monthly in the QA meeting. any patterns will be identified and an action plan will be developed. V. The facility will have the deficient practice on 9-22-16.</p>	09/22/2016

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	<p>the ceiling. Based on interview at the time of record review, the Maintenance Director acknowledged the identified sprinkler locations had not been realigned. Based on observations with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:10 p.m. on 08/23/16, the following sprinkler locations were improperly aligned:</p> <p>a. the sprinkler hanging down out of the ceiling grid by the 400 Hall exit and the sprinkler hanging down in the men's restroom.</p> <p>b. the sprinkler in Room 209, the men's rest room and two sprinklers in the Main Dining Room were each too high on the ceiling and with the two Main Dining Room sprinklers not aligned parallel to the ceiling.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned sprinkler locations were improperly aligned to the ceiling.</p> <p>3.1-19(b) 3.1-19(ff)</p>			

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K 0062 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review, observation and interview; it could not be assured 1 of 1 sprinkler systems was kept in reliable operating condition. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of SafeCare's "Service Notes" documentation dated 02/22/16 during record review with the Maintenance Director from 9:20 a.m. to 11:20 a.m. on 08/23/16, it was stated</p>	K 0062	<p>I. The facility will ensure that the repairs of the sprinkler systems's electric bell and tamper switch will be repaired or replaced. The facility will also keep accurate documentation of repairs and readily available. The facility is also currently working with SafeCare to get the proper escutcheons to replace the existing ones. The maintenance director will also ensure that the sprinkler heads are free of any foreign materials. II. The maintenance director has been in-serviced. Further in-servicing and/or progressive discipline will be administered as necessary. The maintenance director will perform an inspection to review recommendations and requirements made by the facility's inspection entity and ensure they are addressed. III. The deficient practice has the potential to affect all resident, visitors and employees of the facility. The maintenance director will keep an audit tool to ensure that the sprinkler heads are monitored and kept free from foreign material. IV. The administrator or his designee and the maintenance director will review inspections and ensure</p>	09/22/2016
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	<p>"during sprinkler inspection found that outside electric bell have a very low buzz sound when bell is set off. Also found that tamper switch on PIV is bad. (Tamper switch full of corrosion). Send quote to replace PIV Tamper Switch and outside electric bell." Based on interview at the time of record review, the Maintenance Director stated he was unaware of electric bell repair or replacement and the PIV tamper switch has been replaced but acknowledged replacement documentation was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:10 p.m. on 08/23/16, it could not be assured the PIV was replaced.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; it could not be assured 1 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</p>		<p>that repairs are made. Results of the monitoring will be discussed during the monthly QA meeting. Any patterns identified will have an action plan written to identify the issue. V. The facility will have the deficient practice on 9-22-16.</p>	

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	<p>inspected, and the necessary corrective action shall be taken. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of SafeCare's "Fire Hydrants & Water Supply Testing" documentation dated 05/23/16 with the Maintenance Director during record review from 9:20 a.m. to 11:20 a.m. on 08/23/16, one fire hydrant at the front of the facility was inspected and tested within the most recent twelve month period. SafeCare's "Service Call Report" documentation dated 09/11/15 stated "Performed fire hydrant test on one fire hydrant on the property (hydrant in front of facility). Could not perform hydrant test on fire hydrant in back of facility due to broken operational cap on top of hydrant. Order new operational cap for fire hydrant." Based on interview at the time of record review, the Maintenance Director stated the rear fire hydrant operational cap has been replaced but acknowledged repair documentation was not available for review and testing documentation for the rear fire hydrant for the most recent twelve month period was also not available for review. Based on observation with the Maintenance Director during a tour of the facility from</p>			

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	<p>11:20 a.m. to 1:10 p.m. on 08/23/16, the facility has two fire hydrants on the premises one in the front of the facility and one in the rear of the facility.</p> <p>3.1-19(b)</p> <p>3. Based on record review, observation and interview; the facility failed to ensure 19 of over 100 sprinkler heads were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of SafeCare's "Service Notes" documentation dated 08/19/16 during record review with the Maintenance Director from 9:20 a.m. to 11:20 a.m. on 08/23/16, 19 sprinkler head locations were identified as missing an escutcheon. Based on interview at the time of record review, the Maintenance Director stated the escutcheons needed are an older type, SafeCare was looking into finding replacement escutcheons and acknowledged the 19 sprinkler head locations identified in the 08/19/16 report had not been equipped with an</p>			

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	<p>escutcheon. Based on observations with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:10 p.m. on 08/23/16, the following sprinkler locations were not equipped with an escutcheon:</p> <p>a. Laundry Room, women's rest room by the breakroom, men's restroom, by the freezers in the kitchen.</p> <p>b. closet for Room 206, closet for Room 208, closet for Room 210, closet for Room 211, closet for Room 213, rest room for Room 214, closet for Room 215, closet for Room 217.</p> <p>c. Room 301, rest room for Room 305, the closet for Room 307, Room 308 and the closet for Room 308, the closet and rest room for Room 316.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned automatic sprinkler locations each had a missing escutcheon.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>4. Based on observation and interview, the facility failed to replace 8 of over 100 sprinklers which had become corroded, had paint, lint or other foreign materials on them. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in</p>			

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	<p>accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect two 16 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of SafeCare's "Service Notes" documentation dated 08/19/16 during record review with the Maintenance Director from 9:20 a.m. to 11:20 a.m. on 08/23/16, eight sprinkler head locations were identified as having foreign materials on them. Based on interview at the time of record review, the Maintenance Director acknowledged the identified sprinkler locations had not been replaced. Based on observations with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:10 p.m. on 08/23/16, the following sprinkler locations were corroded, had paint on them or were covered with lint:</p> <p>a. paint was on the sprinkler in the corridor by the cart storage room, in the Main Dining Room, in the corridor outside Room 201 and Room 213.</p> <p>b. the sprinkler in the Dish Room Janitor's Closet and in the kitchen by the</p>			

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K 0064 SS=E Bldg. 01	<p>rest room were each corroded. c. each of two sprinklers in the Laundry Room were covered with lint. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned sprinkler locations each had foreign materials attached to them.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p> <p>Based on observation and interview, the facility failed to document inspection of 6 of 15 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no</p>	K 0064	<p>I. The facility will ensure that the portable fire extinguishers are inspected monthly. The facility will document inspections via date and initials of the person conducting the inspection. II. The maintenance director will perform an inspection to ensure that all fire extinguishers beyond the ones mentioned in the 2567 are inspected. Documentation will reflect the monthly inspections. III. The deficient practice has the potential to affect residents who reside in the facility and all others within the facility. Monitoring will be ongoing. IV. The maintenance director will inspect the fire extinguishers on a set day each month. The maintenance director will ensure that all extinguishers are</p>	09/22/2016

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	<p>obvious or physical damage or condition to prevent its operation. This deficient practice could affect 30 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:10 p.m. on 08/23/16, the two portable fire extinguishers in the corridor by Room 301 and by Room 311 each had an inspection tag affixed to the extinguisher which indicated an annual inspection was conducted in January 2016. However, a monthly inspection was not documented for the February and March 2016. In addition, the portable K Class fire extinguisher in the kitchen, the portable fire extinguisher at the main entrance of the kitchen and the two portable fire extinguishers in the corridor in the 100 Hall also had an inspection tag affixed to the extinguishers which indicated an annual inspection was conducted in January 2016 but no monthly inspection was documented for March 2016. Based on interview at the time of the observations, the Maintenance Director stated no other monthly fire extinguisher inspection documentation was available for review and acknowledged a monthly inspection for the aforementioned</p>		<p>inspected on that none are left out of the inspection. The administrator or his designee will perform random audits to ensure that the tags of the extinguishers are initialed and dated on the set inspection date. The maintenance director has been in-serviced and further in-servicing and/or progressive discipline will be given as necessary. Results will be discussed in the monthly QA meeting. If a patten is identified an action plan will be written and implemented. V. The facility will have the deficient practice on 9-22-16.</p>	

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K 0069 SS=D Bldg. 01	portable fire extinguishers was not documented for February and/or March 2016. 3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 1. Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1999 edition, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect four staff and visitors in the kitchen. Findings include: Based on review of Allied Safety Services "Fire Systems Report"	K 0069	I. The facility will ensure that the hood extinguishing system in the kitchen will be inspected per NFPA standards. Furthermore, the documentation will be kept in a binder and readily available for inspection. II. The maintenance director will perform an audit to ensure that no other employees residents or visitors will have the potential to be affected in the future. III. The deficient practice has the potential to affect four staff members and visitors to the kitchen. IV. The maintenance director will keep a calendar to ensure that inspections are being performed in accordance with NFPA standards. The administrator or his designee will perform random audits to ensure that the documentation for inspections are in place. Results	09/22/2016

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	<p>documentation dated 07/08/16 during record review with the Maintenance Director from 9:20 a.m. to 11:20 a.m. on 08/23/16, documentation of semiannual hood extinguishing systems inspection six months prior to 07/08/16 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of semiannual hood extinguishing systems inspection six months prior to 07/08/16 was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire</p>		<p>of the monitoring will be discussed in the monthly QA meeting. V. The facility will have the deficient practice on 9-22-16.</p>	

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	<p>exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect four staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on review of Hoodz "Job Service Report" documentation dated 08/11/16 during record review with the Maintenance Director from 9:20 a.m. to 11:20 a.m. on 08/23/16, documentation of semiannual kitchen exhaust systems inspection six months prior to 08/11/16 was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:10 p.m. on 08/23/16, stickers affixed to the kitchen range hood indicated hood extinguishing systems inspections were conducted by Hoodz on 02/16/15 and 08/11/16. Based on interview at the time of record review and of the observation, the Maintenance Director acknowledged documentation of</p>			

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K 0144 SS=F Bldg. 01	<p>semiannual kitchen exhaust systems inspection six months prior to 08/11/16 was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 9 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be</p>	K 0144	<p>I. The facility will ensure that the generator load test will be conducted monthly per regulation and documented. II. The maintenance director will make sure this documentation is maintained and readily accessible for inspection. III. The deficient practice has the potential to affect all residents, staff and visitors to the facility. IV. The maintenance director will keep a calendar to ensure that inspections are being performed on a specific day. The administrator or his designee will perform random audits to ensure that the documentation for inspections are in place. The maintenance has been educated regarding the importance of maintaining the generator log. If</p>	09/22/2016

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	<p>exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator - Weekly Inspection Checklist" documentation during record review with the Maintenance Director from 9:20 a.m. to 11:20 a.m. on 08/23/16, monthly load testing conducted on 12/17/15, 01/15/16, 2/10/16, 04/12/16 and 6/10/16 did not document the generator was load tested for a minimum of thirty minutes. Monthly load testing documentation for March 2016 was not available for review. In addition, "Power Outage" was the only</p>		<p>necessary, further education and/or progressive discipline will be given if documentation is not kept in compliance. The results will be discussed in the monthly QA meeting. Any patterns identified will have an action plan developed and will be followed until resolved. V. The facility will have the deficient practice on 9-22-16.</p>	

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	<p>information documented for load testing stated to have occurred on 05/11/16, 07/17/16 and 08/10/16. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of a complete record for monthly load testing on and after 12/17/15 was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 6 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. 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 by the authority having jurisdiction. This deficient</p>			

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	<p>practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator - Weekly Inspection Checklist" documentation during record review with the Maintenance Director from 9:20 a.m. to 11:20 a.m. on 08/23/16, documentation of weekly inspections of the starting batteries for the emergency generator for the six week period of 02/22/16 through 04/04/16 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of weekly inspections of the starting batteries for the emergency generator for the aforementioned six week period was not available for review.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 5 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system</p>			

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	<p>within 10 seconds after loss of normal power. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator - Weekly Inspection Checklist" documentation during record review with the Maintenance Director from 9:20 a.m. to 11:20 a.m. on 08/23/16, documentation of emergency generator transfer time for December 2015, March 2016, May 2016, July 2016 and August 2016 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged emergency generator transfer time for the aforementioned five month period was not available for review.</p> <p>3.1-19(b)</p>			

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K 0147 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure all electrical wiring in the facility 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 exposed electrical wires be confined within a junction box with a cover compatible with the box. This deficient practice could affect 16 residents, staff and visitors in the 200 Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:10 p.m. on 08/23/16, electrical wiring for the string of attic mounted lights above the 200 Hall attic were spliced to a five foot long electrical cord equipped with an attached plug above the attic access door. The spliced wires were not confined within a</p>	K 0147	<p>I. The facility will ensure that the electrical wiring for the attic mounted lights above the 200 hall will be confined within a junction box with a cover that is compatible with the box. Any findings were corrected. II. The maintenance director will perform an audit to ensure that no other employees residents or visitors will have the potential to be affected in the future. III. The deficient practice has the potential to affect 16 residents, staff and visitors. IV. The maintenance director will perform random audits to ensure that the wiring remains confined within the junction box. Inservicing of the maintenance director was given. Any further non compliance will result in further education and/or progressive discipline if necessary. Issue will be discussed during monthly QA meeting. an concerns will be corrected immediately. V. The facility will have the deficient practice on 9-22-16.</p>	09/22/2016

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K 0211 SS=B Bldg. 01	<p>junction box with a cover compatible with the box. Based on interview at the time of observation, the Maintenance Director acknowledged the spliced electrical wiring for attic mounted lights above the 200 Hall was not confined within a junction box with a cover compatible with the box.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers shall have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. <p>18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623</p> <p>Based on observation and interview, the facility failed to ensure 1 of over 10</p>	K 0211	I. The facility will ensure that the hand sanitizer was removed from	09/22/2016			

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	<p>alcohol based hand sanitizers were not installed above or adjacent to an ignition source. NFPA 101, in 19.1.1.3 requires all health facilities to be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 5 residents, staff and visitors in the vicinity of the main entrance.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:10 p.m. on 08/23/16, an alcohol based hand sanitizer was installed directly above a light switch in the main entrance lobby. The aforementioned hand sanitizer contained ethyl alcohol as an ingredient as stated on its packaging. Based on interview at the time of observation, the Maintenance Director acknowledged the hand sanitizer in the main entrance lobby was alcohol based and was installed directly above an ignition source.</p> <p>3.1-19(b)</p>		<p>the location above the light switch in the main lobby. Any others found were removed as well. II. The maintenance director will perform an audit to ensure that no other employees residents or visitors will have the potential to be affected in the future. III. The deficient practice has the potential to affect five residents, staff members and visitors in the vicinity of the main entrance. IV. The maintenance director will keep a calendar to ensure that there are no other hand sanitizer installed currently or in the future above any light switches. The administrator will perform random audits to ensure this as well. Random monitoring will be conducted 3 days per week until 4 consecutive weeks of zero negative findings is achieved. Weekly audits will be conducted on an ongoing basis. The maintenance director was educated to ensure that no sanitizers are installed above light switches. This will be discussed during the monthly QA meeting. V. The facility will have the deficient practice on 9-22-16.</p>	