

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 1a B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2014
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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
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K1a0000	<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: 02/26/14</p> <p>Facility Number: 004700 Provider Number: 155741 AIM Number: 100266630</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Friendship Healthcare 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 with a partial basement was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has smoke</p>	K1a0000	<p>This plan of correction is the center's credible allegation of compliance. Preparation and/or completion of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth in the statement of the deficiencies. The Plan of correction is prepared and/or executed solely because it is required by state and federal law.</p>	
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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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	<p>detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 53 and had a census of 40 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached storage shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/10/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K1a0012 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained as a 1 hour fire rated structure for facilities with Type V (111) construction and sprinklered. This deficient practice affects two staff in the vicinity of the Food Storage Pantry in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, a four inch in diameter hole in the ceiling of the Food Storage Pantry for the passage of twenty cables exposed the attic above and failed to maintain the ceiling as a 1 hour fire rated structure. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned hole in the ceiling of the Food Storage Pantry failed to maintain the ceiling as a 1 hour fire rated structure.</p> <p>3.1-19(b)</p>	K1a0012	The repair of the holes in the ceiling will be the corrective action accomplished for those residents found to have been affected by the deficient practice; this will also be the corrective action taken to protect other residents having the potential to be affected by the same deficient practice. An in-service for the Dietary Manager explaining the deficient practice, and a constant observation by the Dietary Manager will be the measure, and assurance program put into place to ensure that the deficient practice does not recur. Additionally, the Maintenance Daily Rounds Checklist will be updated to include checking for holes during rounds. All systemic changes will be completed by April 11, 2014.	04/11/2014	

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K1a0014 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to provide documentation of the flame spread rating for interior finish materials installed in 1 of 6 exitways. This deficient practice could affect 22 residents, staff or 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 1:30 p.m. to 4:00 p.m. on 02/26/14, four walls of the main entrance foyer had wood paneling installed on each wall from the floor to three feet high on the wall. Based on interview at the time of observation, the Maintenance Director stated none of the main entrance foyer walls had been treated with flame retardant material and acknowledged wood paneling flame spread rating documentation was not available for review.</p> <p>3.1-19(b)</p>	K1a0014	<p>The purchase and the application of fire retardant solution is the corrective action that will be accomplished for those residents found to have been affected by the deficient practice. This will also be the corrective action taken to identify how other residents having the potential to be affected by the same deficient practice. The measures that will be put into place to ensure that the deficient practice does not recur will be maintaining documentation of the fire retardant solution in the Maintenance Records. This will be how the corrective action will be monitored and quality assurance program that will be put into place to ensure this deficient practice will not recur. Completion date April 11, 2014.</p>	04/11/2014			

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K1a0018 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure 10 of over 40 corridor doors had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, the following was noted: a. a kick down door stop was affixed to the Administrators Office corridor door and to the Main Dining Room Dutch door which leads to the kitchen. The Main</p>	K1a0018	<p>All doors will be checked to make sure they are not propped open this will be the corrective action accomplished for those residents found to have been affected by the deficient practice, and those residents having the potential to be affected by the same deficient practice will be identified. The measures that will be put into place, and the systemic changes made to ensure that the deficient practice does not recur will be an in-service given on March 14, 2014 to all employees explaining how they need to be on the look out for doors being propped open. Three times a week on the daily rounds check that maintenance performs we will record that all doors are free from obstructions. This will be the quality assurance program we will put into place to ensure the deficient</p>	04/11/2014			

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	<p>Dining Room was open to the corridor.</p> <p>b. waste baskets were used to prop open the corridor door to Rooms N-1, N-5, N-6, N-11, S-3, S-4 and S-9.</p> <p>c. a vacuum cleaner hose attachment was used to prop open the corridor door to the Beauty Shop.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned corridor doors had an impediment to closing and latching, and would not resist the passage of smoke.</p> <p>3.1-19(b)</p>		practice will not recur. Completion date April 11, 2014.	

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K1a0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 4 of 9 hazardous areas such as the laundry, fuel fired heater rooms, maintenance shops and combustible storage rooms over 100 square feet are enclosed with a one hour fire rated barrier and are equipped with self closing doors which latch into the door frame. This deficient practice could affect three staff and visitors in the basement.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, the north door to the laundry, the maintenance shop, the Storage/Linen room and the boiler room entry doors were each equipped with a self closing</p>	K1a0029	<p>Please see Temporary Waiver Request regarding automatic closing of doors and fire stopping gaps in basement area.</p> <p>Nursing staff has been instructed to store the soiled linen barrels away from each other, on opposite ends of the central hall, behind closed doors when not in use. All residents in the building have been identified as having potential to be affected. Maintenance Supervisor will add to the Maintenance Rounds Checklist to view position of items in hallway, including soiled linen barrels, for safe and proper placement. The Maintenance Supervisor will report to the Quality Assurance Committee quarterly regarding the results of his rounds as a method to monitor. Completion date April 11, 2014.</p>	04/11/2014			

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	<p>device but each door failed to fully close and latch into the door frame. Five natural gas fired water heaters were noted in the boiler room. The Storage/Linen room measured 108 square feet and was used to store combustible boxes and supplies. A one and a half inch hole in the maintenance shop door was noted below the door handle. A six inch in diameter hole for a natural gas line and two three inch in diameter holes were noted in the north and east walls of the boiler room. In addition, a five foot long by six inch high gap at the top of the east wall and a ten foot long by three inch gap of the north wall separated the top of each wall from the ceiling and was not fire resistant. Seventeen ceiling joists penetrated the west wall of the laundry and were firestopped or sealed with expandable foam which is not an approved material for maintaining the fire resistance of a fire barrier. Based on interview at the time of the observations, the Maintenance Director acknowledged the entry doors to the aforementioned hazardous areas did not self close and latch into the door frame and the aforementioned hazardous areas were not enclosed with a one hour fire rated barrier.</p> <p>3.1-19(b)</p>			
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	<p>2. Based on observation and interview, the facility failed to ensure 2 of 2 mobile soiled linen carts were stored in an enclosure having a one hour fire resistance rating. This deficient practice could affect 22 residents, staff and visitors in the south smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, two 32 gallon mobile soiled linen carts were unattended and stored next to one another in the corridor of the south smoke compartment near the nurses' station. In addition, the aforementioned soiled linen carts were observed unattended and stored in the corridor of the south smoke compartment near the nurses' station at 9:30 a.m. during the initial walk through of the facility. Based on interview at the time of observation, the Maintenance Director acknowledged two 32 gallon mobile soiled linen carts were not stored in an area providing a one hour fire resistance rating.</p> <p>3.1-19(b)</p>				

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K1a0038 SS=E	<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>1. Based on observation and interview, the facility failed to ensure the ceiling in the means of egress through 1 of 6 exits met or exceeded the minimum headroom. LSC 7.1.5 states the means of egress shall be designed and maintained to provide headroom and shall be not less than 7 feet 6 inches. This deficient practice could affect 30 residents, staff or visitors using the main dining room exit to the back patio.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, the ceiling height in the means of egress from the main dining room exit in the vending machine area to the back patio measured 6 feet 8 3/4 inches. Based on interview at the time of observation, the Maintenance Director acknowledged the ceiling height in the aforementioned means of egress was less than 7 feet 6 inches.</p> <p>3.1-19(b)</p>	K1a0038	<p>Please see waiver request for low ceiling in vending area, sprinkler pipe in the basement stairwell, and tread depth on stairs leading to the basement.</p> <p>Reposting code at front door will be the corrective action taken for all residents, visitors, and staff of the physicality. Everyone has been affected by the deficient practice. The new measures that we will put into place to ensure that the deficient practice does not recur will be a better monitoring system. We have added on Maintenances daily walk through to check all codes at the doors and replace them if needed. This is how the corrective action will be monitored to ensure the deficient practice will not recur. Completion date April 4, 2014.</p> <p>Removal of one of the door locks in each door that has been found in default is the corrective action accomplished for those residents found to have been affected by the deficient practice. This removal of the locks will be the corrective action taken for other residents having the potential to be affected by the same deficient practice. Locks removed and the knowledge of knowing that we are not suppose to have two locks will be the systemic changes made to ensure that the deficient practice</p>	04/04/2014	

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	<p>2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 6 exits was 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 requires 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 residents require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 22 residents, staff or 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 1:30 p.m. to 4:00 p.m. on 02/26/14, the exit door at the main entrance was magnetically locked and could be opened by entering a four digit code, but the code was not posted. The aforementioned exit door is marked with signage as a facility exit. Based on interview at 6:30 p.m. during the exit</p>		<p>does not recur. Educating all office staff in that we are not suppose to have two locks on the doors, and having them to be on the lookout for them will be the corrective action taken in monitoring to ensure the deficient practice will not recur. Completion date April 4, 2014.</p>				

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	<p>conference, the Assistant Administrator and the Director of Nursing stated not all residents have a clinical diagnosis requiring specialized security measures. Based on interview at the time of observation, the Maintenance Director acknowledged the exit door at the main entrance was magnetically locked and could be opened by entering a four digit code, but the code was not posted.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to provide 4 of over 40 corridor doors with not more than one releasing operation. LSC Section 7.2.1.5.4 states a latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches above the finished floor. Doors shall be operable with not more than one releasing operation. Section A.7.2.1.5.4 states examples of devices that might be arranged to release latches include knobs, levers, and panic bars. This deficient practice could affect six staff and visitors.</p> <p>Findings include:</p>			
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	<p>Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, the following was noted:</p> <p>a. the corridor door to the Administrators Office and the Social Services Office each had two locks on the door. A key was required to unlock each door from the corridor.</p> <p>b. the corridor door set to the supply closet in the main entrance foyer had two locks on each door one of which required a key to open and the second lock was a combination lock.</p> <p>c. the corridor door to the Business Office had a lock on the door handle and a second lock which each required a key to open from the corridor.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned corridor doors each required more than one releasing operation to open the door.</p> <p>3-1.19(b)</p> <p>4. Based on observation and interview, the facility failed to ensure the maximum riser height, minimum tread depth and minimum headroom for 1 of 1 stairs met the requirements of Table 7.2.2.2.1(b). Table 7.2.2.2.1(b) requires Class B existing stairs be provided with a</p>			
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	<p>maximum height of stair risers of 8 inches, minimum tread depth of 9 inches and minimum headroom of 6 feet 8 inches. This deficient practice could affect three staff and visitors in the basement.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, the following was noted for the basement stairwell:</p> <ul style="list-style-type: none"> a. a four inch in diameter sprinkler pipe projected ten inches into the 48 inch width of the stairwell and provided four feet of headroom at the bottom two stairs. b. tread depth of 8 1/2 inches. c. riser height measured a minimum 8 3/4 inches. <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the basement stairwell headroom, tread depth and riser height measurements.</p> <p>3.1-19(b)</p>			
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K1a0050 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure 3 of 4 third shift fire drills included the transmission of the fire alarm signal. LSC 18.7.1.2 requires fire drills in ambulatory health care facilities to include the transmission of the fire alarm signal. When drills are conducted between 9:00 p.m. and 6:00 a.m., a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation during record review with the Maintenance Director from 9:35 a.m.</p>	K1a0050	<p>Documentation of fire drills has been corrected. The audible alarm will not be sounded, and thus a signal will not be transmitted between 9 pm and 6 am. The documentation of fire drills will reflect this accurately going forward. All residents have potential to be affected. The fire alarm does transmit a signal every time we test it. Records of fire drills will be reviewed by the Quality Assurance Committee quarterly as a method to monitor. Completion date April 4, 2014.</p>	04/04/2014			

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	<p>to 12:05 p.m. on 02/26/14, fire drill records for the third shift did not include documentation of the transmission if the fire alarm signal. Documentation for the 03/15/13 fire drill conducted at 11:15 p.m. stated "Yes" to "Fire alarm system tested" and "No" to "Monitoring company received signal." Documentation for the 06/25/13 fire drill conducted at 11:30 p.m. stated "No" to "Fire alarm system tested" and "11:43" to "Monitoring called."</p> <p>3.1-19(b) 3.1-51(c)</p>				

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K1a0051 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to install 1 of 7 manual fire alarm box initiating devices in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, section 2-8.1 states each manual fire alarm box shall be securely mounted and the operable part of the fire alarm box shall be not less than 3 1/2 feet and not more than 4 1/2 feet above the floor. Each installed initiating device shall be accessible for periodic maintenance and testing. This deficient practice affects three staff and visitors in the basement.</p>	K1a0051	The repositioning of the pull station is the corrective action accomplished for those residents found to have been affected by the deficient practice. This will also help other residents that have been identified in having the potential to be affected by the same deficient practice. This new systemic changes will be made to ensure that the deficient practice does not recur. Safe Care will monitor to ensure the deficient practice will not recur. Completion date April 4, 2014.	04/04/2014			

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, the operable part of the manual fire alarm box located in the basement corridor outside the laundry was mounted on the wall 5 1/2 feet above the floor. Based on interview at the time of observation, the Maintenance Director acknowledged the operable part of the aforementioned fire alarm box was mounted on the wall more than 4 1/2 feet above the floor.</p> <p>3.1-19(b)</p>			
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K1a0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>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 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. These deficient practices could affect 28 residents, staff and visitors in the vicinity of the employee exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the</p>	K1a0056	<p>Letting Safe Care know about this problem will be what corrective action accomplished for those residents found to have been affected by the deficient practice. This will also aide in the identifying of residents having the potential to be affected by the same deficient practice. Safe Care has come in and placed a new support on pipe to bring us back into compliance. This was the systemic change made to ensure that the deficient practice does not recur. Safe Care will monitor the building on their times of inspection to ensure the deficient practice will not recur. Completion date April 4, 2014.</p>	04/04/2014			

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	<p>facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, a 39 inch horizontal length of steel sprinkler pipe installed in the employee exit corridor was unsupported to a sprinkler. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler location was an unsupported armover greater than 24 inches in length for a steel pipe.</p> <p>3.1-19(b) 3.1-19(ff)</p>			

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K1a0062 SS=F	<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; the facility failed to ensure 1 of 1 automatic sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of SafeCare's "Report of Inspection" quarterly reports for the most recent twelve month period with the Maintenance Director during record review from 9:35 a.m. to 12:05 p.m. on 02/26/14, documentation for the recalibration or replacement of sprinkler system gauges was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on</p>	K1a0062	<p>Safe Care has already replaced the gauges in question this was the corrective action accomplished for those residents and other residents found to have the potential to be affected by this deficient practice. The replacing of the gauges and the knowledge of knowing the gauges need to be replaced every five years will be the systemic changes made to ensure that the deficient practice does not recur. Safe Care will monitor gauges year by year to ensure the deficient practice will not recur Completion date April 4, 2014.</p> <p>Safe Care has already added the spare sprinklers in question this was the corrective action accomplished for those residents and other residents found to have the potential to be affected by this deficient practice. The adding of these spare will be the systemic changes made to ensure that the deficient practice does not recur. Safe Care will monitor spare sprinklers year by year to ensure the deficient practice will not recur. Completion date April 4, 2014.</p>	04/11/2014
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	<p>02/26/14, two of two sprinkler gauges on the sprinkler system riser had a manufacture date of 2008. Based on interview at the time of observation, the Maintenance Director stated recalibration or replacement documentation for sprinkler system gauges was not available for review and acknowledged each of the two gauges had exceeded the five year requirement for recalibration or replacement.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler</p>		<p>The repositioning of the light is the corrective action accomplished for those residents found to have been affected by the deficient practice. This will also help other residents that have been identified in having the potential to be affected by the same deficient practice. This new systemic changes will be made to ensure that the deficient practice does not recur. Maintenance department will monitor all lighting to ensure the deficient practice will not recur. Completion date April 4, 2014.</p> <p>Removal of all boxes to a height of 18" below sprinklers will be the corrective action accomplished for those residents found to have been affected by the deficient practice. This removal of these boxes will be the corrective action taken for other residents having the potential to be affected by the same deficient practice. Boxes removed and the knowledge of knowing that we are not supposed to have them that high will be the systemic changes made to ensure that the deficient practice does not recur. Educating all staff in that we are not supposed to have boxes that high, and having them to be on the lookout for them will be the corrective action taken in monitoring to ensure the deficient practice will not recur. Maintenance Director has added to his walk-through checklist to watch for</p>		

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	<p>wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, no spare sidewall sprinklers were located in the spare sprinkler cabinet. Sidewall sprinkler heads were observed installed in the corridors throughout the facility. Based on interview at the time of observation, the Maintenance Director acknowledged no spare sidewall sprinklers were located on the premises or in the spare sprinkler cabinet.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.1 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as</p>		any items stored too close to the ceiling. Completion date April 11, 2014.				

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	<p>defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could affect three staff and visitors in the basement.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, the following was noted:</p> <p>a. a light fixture suspended from the ceiling in the medical record storage area of the basement Maintenance Office was positioned directly below a pendent sprinkler. In addition, cardboard boxes were stored on shelves within one foot of the ceiling.</p> <p>b. cardboard boxes were stored on shelves within one foot of the ceiling along the west wall of the basement Storage/Linen room.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned light and storage locations provided obstructions to the sprinkler system spray pattern.</p> <p>3.1-19(b)</p>				

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K1a0066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>1. Based on record review, observation and interview; the facility failed to post no smoking signs where oxygen is used in 1 of 28 resident sleeping rooms. This deficient practice could affect 22 residents, staff or visitor in the vicinity of Room S-1.</p> <p>Findings include: Based on review of the facility's "Resident Smoking Policy & Procedure" during record review with the</p>	K1a0066	No smoking signs are now posted at both main entrances for staff and visitors. All residents are identified as having potential to be affected. The posting of these signs has been added to the Maintenance Checklist as a method to monitor. Completion date April 11, 2014. Noncombustible containers have been purchased and placed on the front porch and the rear smoking area. This is the corrective action accomplished for those residents found to have been affected by the deficient practice. All residents are identified as having potential to be	04/11/2014			

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	<p>Maintenance Director from 9:35 a.m. to 12:05 p.m. on 02/26/14, the facility allows resident, staff and visitor smoking at the designated smoking area outside the facility near the Main Dining Room. Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, signs prohibiting smoking within the facility were not posted at the main entries used by the public and staff. Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, an oxygen concentrator was in use for the resident in Room S-1 and a no smoking sign was not posted in the area. Based on interview at the time of observation, the Maintenance Director acknowledged an oxygen concentrator was in use for the resident in Room S-1 and a no smoking sign was not posted in the area.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure ashtrays were provided and cigarette butts were deposited into a noncombustible container for 1 of 2 areas where smoking was permitted. This deficient practice could affect 22 residents, staff or visitors if needing to exit the facility onto the</p>		<p>affected. An in-service for all staff explaining the need for everyone to be on the look out for people not using the cans, and a constant observation by the all staff will be the measure, and assurance program put into place to ensure that the deficient practice does not recur. Completion date April 4, 2014</p>				

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	<p>front patio.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, the outside smoking area on the front patio had in excess of thirty cigarettes strewn about on the ground. Ashtrays of noncombustible material and safe design were not provided nor were metal containers with self-closing cover devices into which ashtrays can be emptied available in this area where smoking was permitted. Based on interview at the time of observation, the Maintenance Director acknowledged visitors disposed of cigarette butts on the ground at the front patio, ashtrays and metal containers were not provided in this area where smoking was permitted.</p> <p>3.1-19(b)</p>				

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K1a0067 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 139 fire dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects 22 residents, staff and visitors in the south hall smoke compartment.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:35 a.m. to</p>	K1a0067	The fire damper (FD003) in the therapy room was inspected and works properly. This inspection was done after the broken damper was replaced. Documentation is in place to reflect this. All residents are identified as having potential to be affected. The dampers are on a schedule to be re-inspected every four years as a method to monitor. Completion date April 11, 2014.	04/11/2014			

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	<p>12:05 p.m. on 02/26/14, it could not be assured the Therapy Room fire damper identified as FD003 was repaired or replaced. Review of SafeCare's "Fire Damper Inspection Checklist" documentation dated 09/16/13 stated the Therapy Room fire damper did not operate correctly and needs to be replaced. Review of the facility's "Fire/Smoke Damper Maintenance Record" documentation dated 09/16/13 stated the Therapy Room fire damper was tested and fully closed on 09/16/13. SafeCare's subsequent "Service Call Report" dated 10/03/13 stated the Therapy Room fire damper "needs measured for replacement" and further work was required to "install and order fire damper." Based on interview at the time of record review, the Maintenance Director stated no additional documentation of fire damper maintenance performed within the most recent four year period was available for review and acknowledged the status of SafeCare's 10/03/13 "Service Call Report" for repair or replacement of the fire damper identified as FD003 in the Therapy Room was not known at the time of the survey. Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, fire damper FD003 was observed installed on the ceiling in the</p>			
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	Therapy Room. 3.1-19(b)			
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K1a0069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>Based on record review 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 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 two staff and visitors in the kitchen.</p>	K1a0069	<p>Having the vender 360 call maintenance supervisor if for any reason they cannot make their appointed time will be the corrective action accomplished for those residents found to have been affected by the deficient practice. This also will be the corrective action taken for other residents having the potential to be affected by the same deficient practice. Maintenance Supervisor will keep a date on his calendar reminding of the date vender 360 should be in the building, this would be the systemic change made to ensure that the deficient practice does not recur. Maintenance supervisor will monitor to ensure the deficient practice will not recur. Completion date April 4, 2014.</p>	04/04/2014			

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	<p>Findings include:</p> <p>Based on review of 360 Services "Service Report" documentation dated 10/17/13 with the Maintenance Director during record review from 9:35 a.m. to 12:05 p.m. on 02/26/14, documentation of a semiannual kitchen exhaust systems inspection six months prior to 10/17/13 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of a semiannual kitchen exhaust systems inspection six months prior to 10/17/13 was not available for review.</p> <p>3.1-19(b)</p>				

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K1a0072 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use for 2 of 6 exits means of egress. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, corridor storage of the following was noted:</p> <ul style="list-style-type: none"> a. a Hoyer lift outside Room S-12. b. a chair scale outside Room S-4. c. two soiled linen carts by the South Nurses' Station. d. a three foot high by one foot wide plastic cabinet used to store personal protective equipment and supplies for isolation resident's isolation equipment was stored in the corridor outside Room N-3 and outside Room N-6. <p>Based on interview at the time of the</p>	K1a0072	<p>The chair scale will be removed from the hallway, as will the isolation equipment outside room 3 and 6. The hoier lift is frequently in use and will be on the units for staff to transfer residents.</p> <p>Maintenance Supervisor will add to the Maintenance Rounds Checklist to view position of items in hallway, including soiled linen barrels, hoier lift and other items, for safe and proper placement. The Maintenance Supervisor will report to the Quality Assurance Committee quarterly regarding the results of his rounds as a method to monitor. Completion date April 11, 2014.</p>	04/11/2014			

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	<p>observations, the Maintenance Director acknowledged corridor storage in the means of egress was not continuously maintained free of all obstructions or impediments to full instant use at the aforementioned locations.</p> <p>3.1-19(b)</p>			

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K1a0074 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on record review, observation and interview; the facility failed to ensure valences and window curtains in 2 of 2 smoke compartments were flame resistant. 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 9:35 a.m. to 12:05 p.m. on 02/26/14, valence and window curtain flame resistant documentation was not available for review. Based on observations with the Maintenance Director during a tour of the</p>	K1a0074	<p>The purchase and the application of fire retardant solution to the curtains is the corrective action that will be accomplished for those residents found to have been affected by the deficient practice. This will also be the corrective action taken to identify how other residents having the potential to be affected by the same deficient practice. The measures that will be put into place to ensure that the deficient practice does not recur will be maintaining documentation of the fire retardant solution in the Maintenance Records. This will be how the corrective action will be monitored and quality assurance program that will be put into place to ensure this deficient practice will not recur. Completion date April 25,</p>	04/25/2014
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	<p>facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, window valences installed in all resident sleeping rooms, except Room N-11 and S-4, had no affixed documentation stating each valence was inherently flame retardant. In addition, each of two window curtains in the Activity Office had no affixed documentation stating each window curtain was inherently flame retardant. Based on interview at the time of record review and of the observations, the Maintenance Director stated the aforementioned valences and window curtains may have been treated with a flame retardant material but acknowledged documentation for flame retardant material treatment and valence and window curtain flame resistant documentation was not available for review.</p> <p>3.1-19(b)</p>		2014.		

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K1a0075 SS=E	<p>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 than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>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 feet area. This deficient practice could affect 22 residents, staff and visitors in the south smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, two 32 gallon mobile soiled linen carts were unattended and stored next to one another in the corridor of the south smoke compartment near the nurses' station. In addition, the aforementioned soiled linen carts were observed unattended and stored in the corridor of the south smoke compartment</p>	K1a0075	<p>Nursing staff has been instructed to store the soiled linen barrels away from each other, on opposite ends of the central hall, behind closed doors when not in use. All residents in the building have been identified as having potential to be affected. Maintenance Supervisor will add to the Maintenance Rounds Checklist to view position of items in hallway, including soiled linen barrels, for safe and proper placement. The Maintenance Supervisor will report to the Quality Assurance Committee quarterly regarding the results of his rounds as a method to monitor. Completion date April 11, 2014</p>	04/11/2014			

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	<p>near the nurses' station at 9:30 a.m. during the initial walk through of the facility. Based on interview at the time of observation, the Maintenance Director acknowledged two 32 gallon mobile soiled linen carts were unattended and stored within a 64 square feet area not protected as a hazardous area.</p> <p>3.1-19(b)</p>			
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K1a0076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3000 cubic feet was separated from a minimum distance of at least five feet from combustible materials, any installed electrical wall fixtures are in fixed locations not less than five feet above the floor, and was equipped with precautionary signs. NFPA 99, Standard for Health Care Facilities, 1999 Edition, Chapter 8-3.1.11.2(c) requires oxidizing gases such as oxygen shall be separated from combustibles by a minimum distance of five feet if the required storage location is protected by an automatic sprinkler system. 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations</p>	K1a0076	<p>Combustible supplies will be removed from the Oxygen storage room. The electrical outlets have been removed from the Oxygen storage room. Signs will be placed on the inside and outside of the door to the Oxygen storage room. All residents have the potential to be affected. Keeping an inspection of the oxygen room will be the measure put into place to ensure that the deficient practice does not recur. Maintenance will add the inspection to its daily walkthrough this will be the corrective action taken to monitor to ensure the deficient practice will not recur. Completion date April 11, 2014</p>	04/11/2014
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	<p>not less than five feet above the floor to avoid physical damage. 8-3.1.11.3 requires a precautionary sign, readable from a distance of 5 feet, shall be conspicuously displayed on the door of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING. This deficient practice could affect 22 residents, staff and visitors in the vicinity of the oxygen storage room and transfilling room in the south smoke compartment.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, three liquid oxygen containers were noted in the oxygen storage and transfilling room. Two foam pads, combustible boxes and supplies were stored within five feet of the containers and two electrical outlets were each located on the wall 45 inches above the floor. In addition, the entry door was labeled as Clean Utility and did not have a precautionary sign posted with regard to oxygen storage and no smoking. Based on interview at the time of the observations, the Maintenance Director acknowledged combustibles were stored</p>			

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	<p>within five feet of liquid oxygen containers, electrical wall fixtures were installed less than five feet above the floor and the oxygen storage room was not equipped with a precautionary sign.</p> <p>3.1-19(b)</p>			

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K1a0130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 hazardous rooms with a fuel fired furnace were kept in safe operating condition. NFPA 101 in 18.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects 28 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, each of three medical waste bins with a 28 gallon capacity were filled with medical waste and were stored up against a natural gas fired furnace in the soiled utility room next to Room N-15. Based on interview at the time of observation, the Maintenance Director acknowledged combustible medical waste bins were stored next to a natural gas fired furnace in the soiled utility room next to Room N-15.</p> <p>3.1-19(b)</p>	K1a0130	<p>The medical waste bins have been removed from the natural gas fired furnace in the soiled utility room. All residents in the building are identified as having potential to be affected. Housekeeping staff will be inserviced to look at the soiled utility room during their cleaning rounds to identify and address any combustible item stored too close to the furnace. Housekeeping supervisor will report to department heads at Morning Meeting any problems noted with items being stored too close to the furnace, as a method to monitor. Completion date April 11, 2014</p>	04/11/2014			

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K1a0143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas where transferring of oxygen takes place was in an area posted with signs indicating transferring of oxygen is occurring and smoking in the area was prohibited. This deficient practice could affect 22 residents, staff and visitors in the vicinity of the oxygen storage room and transfilling room in the south smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on</p>	K1a0143	<p>Signs will be placed on the inside and outside of the door to the Oxygen storage room. All residents have the potential to be affected. Keeping an inspection of the oxygen room will be the measure put into place to ensure that the deficient practice does not recur. Maintenance will add the inspection to its daily walkthrough this will be the corrective action taken to monitor to ensure the deficient practice will not recur. Completion date April 11, 2014</p>	04/11/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 1a B. WING _____		X3) DATE SURVEY COMPLETED 02/26/2014
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203		
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	<p>02/26/14, three liquid oxygen containers were noted in the oxygen storage and transfilling room. The entry door was labeled as Clean Utility and did not have a precautionary sign posted with regard to oxygen transferring and no smoking. Based on interview at the time of observation, the Maintenance Director acknowledged the oxygen storage and transfilling room was not equipped with a sign indicating transferring of oxygen is occurring and smoking is not permitted. Based on interview at 6:30 p.m. during the exit conference, the Assistant Administrator and the Director of Nursing stated transfilling of oxygen is performed in the oxygen storage room.</p> <p>3.1-19(b)</p>				

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K1a0147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 6 of 6 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 22 residents, staff and visitors in the vicinity Room S-1.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, the following was noted:</p> <p>a. a clock radio was plugged into an extension cord in resident sleeping Room S-1.</p> <p>b. a refrigerator was plugged into a power strip in the Food Storage Pantry.</p> <p>c. a microwave oven, coffee pot and refrigerator were plugged into a power strip which was plugged into an extension cord in the basement Maintenance Office. The extension cord was then plugged into a power strip which was plugged into a</p>	K1a0147	<p>A) The clock radio in room S-1 was moved and the extension cord was eliminated.</p> <p>B) The refrigerator in the Food Storage Pantry is plugged directly into the wall electrical outlet. The power strip has been removed.</p> <p>C) Electrical outlets were installed by a licensed electrician in the basement Maintenance office. The microwave oven, coffee pot, and refrigerators are plugged directly into the outlets now, without use of extension cords or power strips.</p> <p>Facility staff has been inserviced on the inappropriateness of electrical extension cord use as well as that we need to avoid use of power strips in sequence, and that high-demand appliances cannot be plugged into power strips.</p> <p>The Maintenance Supervisor will look for inappropriate use of power strips and extension cords on his daily walkthrough rounds and promptly correct any issues found as a method to monitor for continued</p>	04/11/2014
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	<p>third power strip. A second refrigerator and a freezer were plugged into one of each of the aforementioned daisy chained power strips. Based on interview at the time of the observations, the Maintenance Director acknowledged extension cords and power strips were being used as a substitute for fixed wiring at the aforementioned locations.</p> <p>3.1-19(b)</p>		<p>compliance. The Maintenance Supervisor will share the results of his rounds with the QA Committee at least quarterly on an ongoing basis. Completion date April 11, 2014.</p>	

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K1a0211 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</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 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. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>Based on observation and interview, the facility failed to ensure 2 of 28 alcohol based hand sanitizers in resident sleeping rooms were not installed adjacent to an ignition source. NFPA 101, in 18.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 22 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:00 p.m. on 02/26/14, an alcohol based hand sanitizer</p>	K1a0211	<p>The dispensers in S4 and S9 bathrooms are soap dispensers, not alcohol hand sanitizer dispensers. However, propylene glycol is listed as an ingredient in the soap. We will replace this soap with a liquid hand soap that does not contain alcohol. Any residents or staff using those two restrooms have potential to be affected. The people responsible for purchasing liquid soap will be inserviced regarding hand soap not containing alcohol. Housekeeping staff will be inserviced as well. All liquid hand soap containing alcohol will be removed from the building to prevent it from inadvertently being installed in a soap dispenser close to an electrical outlet. Completion date April 11, 2014.</p>	04/11/2014			

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	<p>was installed one inch from an electrical outlet in the bathroom for resident sleeping Room S-4 and Room S-9. The aforementioned alcohol based hand sanitizer locations had propylene glycol listed as an ingredient on the packaging of the sanitizer. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned hand sanitizer locations were alcohol based and were installed adjacent to an ignition source.</p> <p>3.1-19(b)</p>			
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