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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155206 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>03/13/2013 |
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| K010000 | <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: 03/13/13</p> <p>Facility Number: 000113<br/>Provider Number: 155206<br/>AIM Number: 100287670</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Brownsburg Health Care Center 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 III (200) construction and fully sprinklered except for the attached Maintenance Shop. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the</p> | K010000 |  |  |
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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>corridor, except for the Service Corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms except the twelve resident sleeping rooms in Wing 4. The facility has a capacity of 160 and had a census of 93 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has a Maintenance Shop and two detached storage buildings which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/21/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> |               |   |                      |

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| K010011<br>SS=E   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD</p> <p>If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to provide a fire barrier having at least a two hour fire resistive construction for 1 of 1 attached combustible buildings. This deficient practice could affect 18 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:50 a.m. to 3:40 p.m. on 03/13/13, the Maintenance Shop is attached to Wing 8 of the building by a breezeway and the attic of the breezeway. A fire rated wall was not observed in the attic of the breezeway or adjoining Maintenance Shop. The attic breezeway and the attached Maintenance Shop interior walls, ceiling, attic and roof were of wood construction. The Maintenance Shop attic is accessed by a ladder and is used for combustible supply storage. Based on interview at the time of the observations, the Maintenance Director</p> | K010011   | There were no residents identified as being affected by this deficiency. All facility residents have the potential to be affected. No residents were affected. On 3/20/13 a fire rated wall was installed in the attic of the breezeway to the Maintenance shop. Any future identified concerns will be addressed in the monthly Quality Assurance meeting. | 03/20/2013  |  |   |  |

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|                    | <p>acknowledged the aforementioned areas were of wood construction and attached to the building without a fire barrier having at least a two hour fire resistive construction.</p> <p>3.1-19(b)</p> |               |   |                      |

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| K010012<br>SS=E   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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 attached buildings were of an acceptable construction Type. This deficient practice could affect 18 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:50 a.m. to 3:40 p.m. on 03/13/13, the Maintenance Shop is attached to Wing 8 of the building by a breezeway and the attic of the breezeway. The attic breezeway and the attached Maintenance Shop interior walls, ceiling, attic and roof were of wood construction. The Maintenance Shop attic is accessed by a ladder and is used for combustible supply storage. The breezeway attic and the Maintenance Shop attic areas are not provided with automatic sprinklers. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned areas were of wood construction and attached to the building without an automatic sprinkler system.</p> | K010012   | There were no residents identified as being affected by this deficiency. All facility residents have the potential to be affected. No residents were affected. An automated sprinkler system will be installed in the breezeway and Maintenance shop attics. Any future identified concerns will be addressed in the monthly Quality Assurance meeting. | 04/12/2013  |  |   |  |

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|                          | 3.1-19(b)  |                     |  |                            |

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| K010017<br>SS=E   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 corridors open to the Dining Room was provided with an electrically supervised automatic smoke detection system. Exception No. 1 to LSC Section 19.3.6.1 states smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 shall be permitted to have spaces open to the corridor provided the following criteria are met:</p> <p>(a) the spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) the corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with</p> | K010017   | There were no residents identified as being affected by this deficiency. Forty-eight residents have the potential to be affected. No residents were affected. Electrically supervised automatic smoke detectors will be installed in the sixty foot service corridor of the service hall. Any future identified concerns will be addressed in the monthly Quality Assurance meeting. | 04/12/2013  |  |   |  |

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|                    | <p>19.3.4 or the smoke compartment in which the space is located is protected throughout by quick response sprinklers. (c) the open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4 or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) the space does not obstruct access to required access. This deficient practice could affect 48 residents, staff or visitors in the vicinity of the Service Corridor.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:50 a.m. to 3:40 p.m. on 03/13/13, the Service Corridor is open to the Wing 3 corridor which is open to the Dining Room. The Service Corridor is not provided with an electrically supervised automatic smoke detection system for the sixty foot length of the corridor. The automatic sprinkler system observed in the Service Corridor was not equipped throughout with quick response sprinklers. Based on interview at the time of the observations, the Maintenance Director acknowledged the Service Corridor is not provided with an</p> |               |   |                      |

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|                    | electrically supervised automatic smoke detection system for the sixty foot length of the corridor.<br><br>3.1-19(b)   |               |   |                      |

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| K010025<br>SS=E   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure openings through 2 of 7 smoke barriers were protected to maintain the smoke resistance of each smoke barrier. This deficient practice could affect 54 residents, staff or visitors in Wing 4 and Wing 5.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:50 a.m. to 3:40 p.m. on 03/13/13, the following was noted:</p> <p>a. the smoke barrier wall in the attic above the corridor in Wing 4 had eight openings through the concrete block wall which did not extend to the underside of the roof. Each of the eight openings above the concrete block measured six inches long by three inches high.</p> <p>b. the smoke barrier wall in the attic above the corridor in Wing 5 had nine</p> | K010025   | There were no residents identified as being affected by this deficiency. Fifty-four residents have the potential to be affected. No residents were affected. All openings in the smoke barrier walls in the attic above wings 4 and 5 were repaired on 3/20/13. Any future identified concerns will be addressed in the monthly Quality Assurance meeting. | 03/20/2013  |  |   |  |

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|                    | <p>openings through the concrete block wall which did not extend to the underside of the roof. Each of the nine openings above the concrete block measured six inches long by three inches high.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned openings in the smoke barrier wall in the attic above the corridor in Wing 4 and Wing 5 failed to maintain the smoke resistance of each smoke barrier.</p> <p>3.1-19(b)</p> |               |   |                      |

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| K010029<br>SS=E   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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>Based on observation and interview, the facility failed to ensure 2 of 16 doors serving hazardous areas such as soiled linen rooms and storage rooms greater than fifty square feet in size and used to store combustible materials are provided with self closing devices to close and latch each door into the door frame. This deficient practice could affect 46 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:50 a.m. to 3:40 p.m. on 03/13/13, the following was noted:</p> <p>a. the Wing 3 soiled linen room contained two mobile 32 gallon soiled linen receptacles with soiled linen in each receptacle and the access door was not equipped with a self closing device to</p> | K010029   | There were no residents identified as being affected by this deficiency. Forty-six residents have the potential to be affected. No residents were affected. A self-closing device was installed on the door to the wing 3 soiled linen closet on 3/13/13. Room 610 was emptied of all stored items. Any future identified concerns will be addressed in the monthly Quality Assurance meeting. | 03/20/2013  |  |   |  |

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|                    | <p>close and latch the door into the door frame.</p> <p>b. Room 610 was being used to store picture frames, chairs and furniture and the access door was not equipped with a self closing device to close and latch the door into the door frame. Room 610 measured 225 square feet.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned hazardous areas access doors were each not equipped with a self closing device to close and latch the door into the door frame.</p> <p>3.1-19(b)</p> |               |   |                      |

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| K010038<br>SS=E   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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 provide 3 of over 100 corridor room 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 24 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:50 a.m. to 3:40 p.m. on 03/13/13, the following was noted:</p> <p>a. the corridor door to the closet by Room 403 has two locks on the door, and a key was needed to unlock each lock on the door.</p> | K010038   | There were no residents identified as being affected by this deficiency. Twenty-four residents as well as staff and visitors have the potential to be affected. No one was affected. One lock was removed from the corridor door to the closet by room 403. One door knob was removed on the corridor door to the storage room by room 708. One lock was removed from the corridor room to the Medical Records room. Any future identified concerns will be addressed in the monthly Quality Assurance meeting. | 03/14/2013  |  |   |  |

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|                    | <p>b. the corridor door to the storage room by Room 708 has two door knobs on the door with the lower door knob requiring a key to unlock the door.</p> <p>c. the corridor door to the Medical Records room has two locks on the door, and required a key to unlock the door. 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> |               |   |                      |

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| K010052<br>SS=E   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on observation and interview, the facility failed to install 1 of 46 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect 18 residents, staff and visitors in the vicinity of the Activities Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 3:40 p.m. on 03/13/13, the smoke detector on the ceiling in the corridor outside the Activities Room room was located one foot from an air return vent. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned smoke detector location</p> | K010052   | There were no residents identified as being affected by this deficiency. All residents have the potential to be affected. No residents were affected. The smoke detector on the ceiling in the corridor outside the Activities Room will be moved to at least three feet from the air return vent. Any future identified concerns will be addressed in the monthly Quality Assurance meeting. | 04/12/2013  |  |   |  |

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|   | was installed on the ceiling less than three feet from an air return vent.<br><br>3.1-19(b)                            |   |   |                      |   |

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| K010056<br>SS=E   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD</p> <p>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>1. Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was installed in accordance with NFPA 13, 1999 Edition, Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, 1999 Edition, Section A-5-1 states where buildings or portions of buildings are of combustible construction or contain combustible material, standard fire barriers should be provided to separate the areas that are sprinkler protected from adjoining unsprinklered areas. This deficient practice could affect 18 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the</p> | K010056   | There were no residents identified as being affected by this deficiency. Eighteen residents have the potential to be affected as well as staff and visitors. No one was affected. A fire rated wall was installed in the attic breezeway on 3/20/13. An automated sprinkler system will be installed in the attic of the Maintenance shop. One of three sprinklers in the Main Entrance Reception area was removed on 3/18/13, leaving the other 2 sprinklers at least 62 inches apart. Any future identified concerns will be addressed in the monthly Quality Assurance meeting. | 03/20/2013  |  |   |  |

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|                    | <p>Maintenance Director during a tour of the facility from 10:50 a.m. to 3:40 p.m. on 03/13/13, the Maintenance Shop is attached to Wing 8 of the building by a breezeway and the attic of the breezeway. A fire rated wall was not observed in the attic breezeway and neither the attic breezeway or adjoining Maintenance Shop was provided with automatic sprinkler protection. The attic breezeway and the attached Maintenance Shop interior walls, ceiling, attic and roof were of wood construction. The breezeway attic and the Maintenance Shop attic are not separated from the areas below by fire resistive construction. The Maintenance Shop attic is accessed by a ladder and is used for combustible supply storage. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned areas were attached to the building with no rated fire wall separation, was of wood construction and was not provided with automatic sprinkler protection.</p> <p>3.1-19(b)<br/>3.1-19(ff)</p> <p>2. Based on observation and interview, the facility failed to ensure an automatic sprinkler system was installed in 1 of 1 Main Entrance Reception areas in accordance with NFPA 13, 1999 Edition, Installation of Sprinkler Systems, to</p> |               |   |                      |

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|   | <p>provide complete coverage for all portions of the building. NFPA 13, Section 5-6.3.4, "Minimum Distance Between Sprinklers" states sprinklers shall be spaced not less than six feet (72 inches) on center. This deficient practice could affect 18 residents, staff and visitors in the vicinity of the Main Entrance Reception area.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 3:40 p.m. on 03/13/13, two of three sprinklers installed in the Main Entrance Reception area were installed 62 inches apart from one another on the ceiling. Based on interview at the time of observation, the Maintenance Director acknowledged two sprinklers installed in the Main Entrance Reception area were installed less than six feet apart from one another on the ceiling.</p> <p>3.1-19(b)</p> |   |   |   |  |   |  |

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| K010062<br>SS=E   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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 observation and interview, the facility failed to replace 2 of over 100 sprinklers in the facility. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in 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 24 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:50 a.m. to 3:40 p.m. on 03/13/13, the automatic sprinkler in the Housekeeping Supply closet by Room 410 and the automatic sprinkler in the exterior canopy outside the Boiler/Mechanical Room had each become corroded and had turned green. Based on interview at the time of</p> | K010062   | <p>There were no residents identified as being affected by this deficiency. Twenty-four residents as well as staff and visitors have the potential to be affected. No one was affected. The automatic sprinkler in the Housekeeping Supply closet by room 410 was replaced on 3/18/13. The sprinkler in the ceiling of the restroom in the Activities room was replaced on 3/18/14. Eighteen residents, staff and visitors have the potential to be affected. No one was affected. One sprinkler head in the exterior canopy outside the Boiler/Mechanical room was replaced and the escutcheon plate was installed correctly on 3/18/13. Two staff and visitors have the potential to be affected by this deficiency. No one was affected. Any future identified concerns will be addressed in the monthly Quality Assurance meeting.</p> | 03/20/2013  |  |   |  |

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|                    | <p>observation, the Maintenance Director acknowledged the aforementioned automatic sprinkler locations were each corroded.</p> <p>3.1-19(b)</p> <p>2. 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 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 18 residents, staff and visitors in the vicinity of the restroom for the Activities Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 3:40 p.m. on 03/13/13, one sprinkler head is installed</p> |               |   |                      |

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|   | <p>on the ceiling in the restroom for the Activities Room but the sprinkler head does not fully protrude from the ceiling which served to obstruct the spray pattern of the sprinkler head. Based on interview at the time of observation, the Maintenance Director stated the sprinkler head is not a recessed sprinkler head and acknowledged the sprinkler head spray pattern is obstructed by the ceiling by not fully protruding from the ceiling.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads in the exterior canopy outside the Boiler/Mechanical Room was 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 two staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 3:40 p.m. on 03/13/13, the automatic sprinkler head in the exterior canopy outside the Boiler/Mechanical Room had a missing</p> |   |   |   |  |   |  |

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|                    | <p>escutcheon plate which left a two inch opening in the canopy ceiling. Based on interview at the time of observation, the Maintenance Director acknowledged the automatic sprinkler head in the exterior canopy outside the Boiler/Mechanical Room had a missing escutcheon plate which left a two inch opening in the canopy ceiling.</p> <p>3.1-19(b)</p> |               |   |                      |

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| K010067<br>SS=B   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ventless gas fireplaces was connected to a chimney or vent and installed in accordance with Exception No. 2 to LSC Section 19.5.2.2. Exception No. 2 states the fireplace shall be equipped with a fireplace enclosure guaranteed against breakage up to a temperature of 650 degrees Fahrenheit and constructed of heat tempered glass or other approved material. In addition, LSC 9.2.2 states ventilating or heat producing equipment shall be in accordance with NFPA 54, National Fuel Gas Code, 1999 Edition. NFPA 54 defines a decorative appliance for installation in a vented fireplace as a self contained, freestanding, fuel-gas burning appliance designed for installation only in a vented fireplace and whose primary function lies in the aesthetic effect of the flame. Section 6.6.2 states a decorative appliance for installation in a vented fireplace shall be installed only in a vented fireplace having a working chimney flue and constructed of noncombustible materials. This deficient practice could affect two residents, staff and visitors in the Main</p> | K010067   | There were no residents identified as being affected by this deficiency. Two residents, staff and visitors have the potential to be affected. No one was affected. The ventless fireplace will be disconnected and will not serve as a functioning fireplace in the future. It will be kept for aesthetics only. Any future identified concerns will be addressed in the monthly Quality Assurance meeting. | 04/12/2013  |  |   |  |

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|   | <p>Entrance reception area.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 3:40 p.m. on 03/13/13, the Main Entrance reception area has a self contained, free standing natural gas fired fireplace which was not connected to a chimney or vent. The front opening of the fireplace was covered with a mesh screen. Two residents were observed sitting in the Main Entrance reception area by the fireplace. Based on interview at the time of observation, the Maintenance Director acknowledged the Main Entrance reception area natural gas fireplace was not connected to a chimney or vent and did not have a front enclosure constructed of heat tempered glass or other approved material.</p> <p>3.1-19(b)</p> |   |   |                      |   |

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| K010076<br>SS=E   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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.<br/>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 were enclosed with a separation of 1 hour fire resistive construction. This deficient practice could affect 18 residents and any staff or visitor in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 3:40 p.m. on 03/13/13, the entry door to the oxygen storage and transfilling room in Wing 8 had no fire resistance rating label attached to the door. Nine, four wheeled portable liquefied oxygen containers were observed stored in the oxygen storage and transfilling room. Based on interview at the time of observation, the Maintenance Director acknowledged the entry door for</p> | K010076   | There were no residents identified as being affected by this deficiency. Eighteen residents, staff and visitors have the potential to be affected. No one was affected. The oxygen storage and transfilling room in wing 5 (2567 incorrectly identified the location as wing 8) will have a door installed with a label indicating that it is a 1 hour fire resistive door. Any future identified concerns will be addressed in the monthly Quality Assurance meeting. | 04/12/2013  |  |   |  |

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|                    | the oxygen storage and transfilling room in Wing 8 was not one hour fire rated.<br><br>3.1-19(b)                       |               |   |                      |

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| K010143<br>SS=E   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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.<br/>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 separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect 18 residents and any staff or visitor in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 3:40 p.m. on 03/13/13, the entry door to the oxygen storage and transfilling room in Wing 8</p> | K010143   | There were no residents identified as being affected by this deficiency. Eighteen residents, staff and visitors have the potential to be affected. No one was affected. A 1 hour fire rated door will be installed on the oxygen and transfilling room in wing 5 (2567 incorrectly identified the location as wing 8). Any future identified concerns will be addressed in the monthly Quality Assurance meeting. | 04/12/2013           |   |

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|                    | <p>had no fire resistance rating label attached to the door. Nine, four wheeled portable liquefied oxygen containers were observed stored in the oxygen storage and transfilling room. Based on interview at the time of observation, the Maintenance Director acknowledged the entry door for the oxygen storage and transfilling room in Wing 8 was not one hour fire rated.</p> <p>3.1-19(b)</p> |               |   |                      |

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| K010144<br>SS=C   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located outside of the room where the prime mover is located. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 3:40 p.m. on 03/13/13, a remote shut off device was not found for the 50 kilowatt emergency generator. The nameplate on the emergency generator stated the unit was manufactured in November 2012. Based on interview at the time of observation, the Maintenance Director stated the emergency generator was manufactured in</p> | K010144   | There were no residents identified as being affected by this deficiency. All residents, staff and visitors have the potential to be affected. No one was affected. A remote emergency shut off for the emergency generator will be installed. Any future identified concerns will be addressed in the monthly Quality Assurance meeting. | 04/12/2013           |   |

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|                    | <p>2012 and acknowledged there is no remote emergency shut off for the emergency generator.</p> <p>3.1-19(b)</p>       |               |   |                      |

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| K010147<br>SS=E   | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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 3 of 3 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 four residents, staff and visitors in Room 712 and Room 806.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:50 a.m. to 3:40 p.m. on 03/13/13, the following was noted:</p> <p>a. the pump for an air mattress used in a resident bed in Room 712 was plugged into a power strip under the bed. In addition, a refrigerator was plugged into a second power strip used in Room 712.</p> <p>b. a refrigerator was plugged into a power strip in resident Room 806.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged power strips were utilized in the aforementioned locations.</p> <p>3.1-19(b)</p> | K010147   | The residents in room 712 and 806 were identified as being affected by this deficiency. Four residents, staff and visitors have the potential to be affected. No one was affected. Power strips were removed from rooms 712 and 806 on 3/29/13. Any future identified concerns will be addressed in the monthly Quality Assurance meeting. | 03/29/2013  |  |   |  |

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| K019999   | <p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(a) The facility must be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel, and the public.</p> <p>This State Rule has not been met as evidenced by:<br/>Based on record review and interview, the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 85 of 85 resident sleeping rooms. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Smoke Detector Maintenance Log for (Year)" documentation with the Maintenance Director during record review from 9:15 a.m. to 10:50 a.m. on 03/13/13, an itemized listing of monthly battery operated smoke detector testing for each resident sleeping room location was not available for review. The facility has resident sleeping rooms in eight</p> | K019999   | <p>There were no residents identified as being affected by this deficiency. All residents, staff and visitors have the potential to be affected. No one was affected. The battery-operated smoke detector maintenance log that was presented to inspectors indicated detectors had been inspected monthly by wing. The log has been changed to document monthly inspection of each detector in each resident room. Smoke detectors on wing 4 were removed during the renovation of that wing. Smoke detectors were installed in all the resident rooms on wing 4 on 3/13/13. Twenty-four residents have the potential to be affected. No residents were affected.</p> | 04/01/2013  |  |   |  |

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|   | <p>wings and the results of monthly checks of battery operated smoke detectors are entered by wing, and not by room on the aforementioned documentation for the period of May 2012 through February 2013. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of the periodic testing and cleaning for battery operated smoke detector in each resident sleeping rooms was not available for review.</p> <p>3.1-19(a)</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by:<br/>Based on observation and interview, the</p> |   |   |   |  |   |  |

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|                    | <p>facility failed to continuously provide smoke detectors in 12 of 85 resident sleeping rooms. This deficient practice could affect 24 residents in the facility.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:50 a.m. to 3:40 p.m. on 03/13/13, a smoke detector was not observed in each of twelve Wing 4 resident sleeping rooms. Residents were observed in the Wing 4 resident sleeping rooms. Based on interview at the time of the observations, the Maintenance Director stated Wing 4 resident sleeping room smoke detectors had been temporarily removed for painting, the resident sleeping rooms are currently occupied, and he acknowledged smoke detectors were not provided for twelve Wing 4 resident sleeping rooms.</p> <p>3.1-19(ff)</p> |               |   |                      |