

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155694	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2014
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NAME OF PROVIDER OR SUPPLIER BETZ NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706
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K010000	<p>A Life Safety Code Recertification and State Licensure was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/07/14</p> <p>Facility Number: 000306 Provider Number: 155694 AIM Number: 100273860</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Betz Nursing Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a</p>	K010000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	
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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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K010018 SS=E	<p>capacity of 115 and had a census of 100 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had an unsprinklered generator room and a pole barn providing storage of maintenance equipment and general storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/14/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p>			

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	<p>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. Based on observation and interview, the facility failed to ensure 1 of 1 Activity room corridor doors closed and latched into the door frame. This deficient practice could affect any of the 6 residents in the Activity room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 08/07/14 at 2:15 p.m., the door knob on the corridor door to the Activity room was locked in the open position and the door failed to latch into the door frame. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K010018	<p>It is the practice of this provider to ensure that corridor doors close and latch into the door frames. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The maintenance supervisor/designee has ensured that the activity room corridor door latches into the frame. All other doors were checked for compliance. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Six residents attending activities being held inside the activity room had the potential to be affected by the alleged deficient practice. The maintenance supervisor/designee has ensured that the door latches into the frame. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Activity staff will be in-serviced regarding the need to ensure that the corridor door latches into the frame and notify maintenance supervisor/designee immediately if it does not. Additionally, maintenance director/designee will check doors latch into frames</p>	08/22/2014

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air 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 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect any number of residents in the 400 hall, 500 hall, 700 hall and in the main dining room.</p> <p>Findings include:</p>	K010025	<p>monthly for compliance. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance supervisor/designee will monitor monthly for three months and report findings at monthly safety committee meeting. Then it will be monitored as directed in preventive maintenance manual.</p> <p>It is the practice of this provider to ensure that ceiling smoke barriers provide a one half hour fire resistance rating. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The maintenance supervisor/designee has ensured that the ceiling smoke barriers provide at least one half hour of fire resistance and are continuous from outside wall to outside wall. Cracked caulk has been replaced in 500</p>	08/26/2014			

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	<p>Based on observation and interview with the Maintenance Supervisor on 08/07/14 from 12:54 p.m. to 3:45 p.m., he acknowledged the following ceiling smoke barrier deficiencies:</p> <p>a. in the 500 hall mechanical room there were two penetrations where the fire caulk had dried and pulled away from the hole leaving a one half inch gap,</p> <p>b. in the 400 hall mechanical room there were four unsealed penetrations ranging in size from one eighth inch to one inch,</p> <p>c. two unsealed penetrations in the laundry room closet ceiling measuring one inch,</p> <p>d. above the ceiling tile at the center fire barrier wall near the laundry room the attic access panel had been removed and the Maintenance Supervisor was unable to locate it,</p> <p>e. above the ceiling tile at the fire wall near the main dining room, wires were run through the opening preventing the attic access panel from dropping into place leaving a one fourth inch gap,</p> <p>f. above the ceiling tile at the 700 hall fire barrier wall, the attic access panel was broken in two corners leaving a one inch gap.</p> <p>Measurements were provided by the Maintenance Supervisor at the time of the observations.</p>		<p>hall mechanical room, 400 hall mechanical room and laundry room closet. Ceiling access panels have been replaced at the center fire barrier wall near the laundry room, above the ceiling tile at the fire wall near the main dining room, and above the ceiling tile at the 700 hall fire barrier wall. Maintenance director/designee inspected all other fire barrier walls to ensure penetrations were sealed and access panels were in place. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Up to 62 residents(400, 500, and 700 halls)have the potential to be affected by the alleged deficient practice. Repair of missing caulk and replacement of access panels was completed by maintenance supervisor What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Preventive maintenance schedule is implemented that will include checking access panels and verifying that penetrations of the smoke barriers are properly sealed. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance supervisor/designee will monitor per preventive maintenance manual</p>		

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K010038 SS=E	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 7 exit access corridors was readily accessible and unobstructed at all times. This deficient practice could affect residents in 1 of 8 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation and interview with the Maintenance Supervisor on 08/07/14 at 2:30 p.m., he acknowledged there were three rolling clean laundry carts stored in the center corridor near the laundry room from 12:30 p.m. to 2:30 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 11 exit doors were accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section</p>	K010038	<p>schedule. He will immediately repair any openings to ensure compliance. He will report his findings monthly for 3 months to the safety committee, and quarterly thereafter.</p> <p>It is the practice of this provider to ensure that exits are readily accessible at all times. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The maintenance supervisor/designee has ensured that rolling clean laundry carts will not be stored in the hallway. Signage that reads 'PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS' is on order and will be installed as soon as received from vendor. All other doors and hallways were assessed for compliance. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents had the potential to be affected by the alleged deficient practice. Maintenance supervisor/designee has moved the rolling clean linen carts and ordered the signage for installation. What measures will be put into place or what systemic</p>	08/26/2014	

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K010044 SS=E	<p>7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" This deficient practice could affect residents in 2 of 8 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 08/07/14 at 1:52 p.m. and then again at 2:20 p.m., the exit doors from the 600 lounge and the activity room were equipped with electromagnetic locks that released after pushing the door for 15 seconds but they lacked the signage. This was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-15(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the</p>	K010044	<p>changes will you make to ensure that the deficient practice does not recur?Housekeeping/Laundry supervisor will monitor positions of laundry carts daily. Monthly safety inspection report will include checking for position of rolling laundry carts as well as verifying that signage is in place on all doors equipped with electromagnetic locks that release after pushing the door for 15 seconds. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance supervisor/designee will report any negative findings immediately to executive director and also will report at monthly safety meeting.</p> <p>It is the practice of this provider to ensure that single fire exit doors</p>	08/21/2014	

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	<p>facility failed to ensure 1 of 1 single fire doors was properly maintained. NFPA 80, Section 15-2.5.4 requires when holes are left in a door or frame due to changes or removal of hardware or plant-ons, the holes shall be repaired by the following methods: install steel fasteners that adequately fill the holes or fill the screw or bolt holes with the same material as the door or frame. This deficient practice could affect residents in 2 of 8 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 08/07/14 at 12:50 p.m., there was a one half inch hole below the handle of the single fire door near the main dining room. Based on an interview with the Maintenance Supervisor at the time of observation, he thought the hole was from a missing piece of hardware that had been removed from the fire door.</p> <p>3.1-19(b)</p>		<p>are properly maintained What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The maintenance supervisor/designee has repaired the single fire exit door by installing a steel fastener that adequately fills the hole left from changing the hardware. All other singly fire exit doors were inspected by maintenance director/designee for compliance. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 47 residents had the potential to be affected by the alleged deficient practice. Maintenance supervisor/designee has replaced the missing fastener in the door hardware. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Single fire exit doors will be checked per the preventive maintenance schedule. Maintenance supervisor will replace any hardware parts that are found to be missing immediately. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance supervisor/designee will report any negative findings immediately to executive director and also will report at monthly safety meeting.</p>		

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K010045 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to ensure the failure of any single fixture or bulb at 1 of 1 of the 200 hall west exits would not leave the area in darkness. This deficient practice could affect any of the 12 residents on the 200 hall.</p> <p>Finding include:</p> <p>Based on observation with Maintenance Supervisor on 08/07/14 at 12:30 p.m., the 200 hall west exit was equipped with a single light fixture with a single bulb. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K010045	<p>It is the practice of this provider to illuminate egress so that the failure of any single lighting fixture(bulb)will not leave the area in darkness. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The electrician hired by the provider replaced the one bulb fixture at the 200 exit with a 2 bulb fixture on 8-15-2014. All other exits were verified by maintenance supervisor/designee to have 2 bulb fixtures and be in compliance. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 12 residents had the potential to be affected by the alleged deficient practice. Maintenance supervisor had the one bulb fixture replaced with a 2 bulb fixture by contracted electrician on 8-15-2014. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Exit light inspection is part of the preventive maintenance program currently in place in the facility. Maintenance supervisor/designee</p>	08/15/2014	

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K010050 SS=F	<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 fire drills were conducted quarterly on each shift for 2 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Monthly Fire Drill Report" with the Maintenance</p>	K010050	<p>will check all exit lights/bulbs according to schedule. Defective bulbs will be replaced immediately. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Results of the exit light inspection will be reviewed in monthly safety meeting monthly for 3 months and then quarterly for the remainder of the 12 month period.</p> <p>It is the practice of this provider to conduct fire drills at unexpected times at least quarterly on each shift. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A fire drill schedule is now written and will be implemented so that drills are conducted on each shift once per quarter. How will you identify other residents having the potential to be affected by the same deficient practice and what</p>	08/26/2014			

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K010062 SS=E	<p>Supervisor on 08/07/14 at 11:35 a.m., there was no record of a first and a third shift fire drill for the first quarter of 2014, or a third shift fire drill for the fourth quarter of 2013. Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available for review to verify these drills were conducted.</p> <p>3.1-19(b) 3.1-51(c)</p> <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 observation and interview, the facility failed to replace the loaded sprinkler heads in 1 of 1 overhangs at the</p>	K010062	<p>corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Maintenance director/designee will ensure the schedule is followed and all shifts have a fire drill conducted at least once per quarter. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Fire drill schedule (generic/without dates or times) for entire year has been given to all IDT members to facilitate compliance. Maintenance supervisor/designee is responsible to schedule exact dates and times and communicate that with ED for verification of each shift being completed once quarterly. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Fire drills are discussed at every monthly safety meeting. Proper shift timing will be verified to ensure each shift is receiving a drill quarterly.</p> <p>It is the practice of this provider to continuously maintain the sprinkler system in reliable</p>	08/26/2014	

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	<p>600 hall exit. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected 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 11 residents in the 600 hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 08/07/14 at 2:03 p.m., the sprinkler heads in the 600 hall overhang were corroded with a green substance. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the sprinkler spray pattern for 1 of 1 activity storage closets in the Cottage was unobstructed. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire</p>		<p>operating condition, the spray unobstructed, and ensure it is inspected and tested periodically. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The corroded sprinkler head in the 600 hall over hang is to be replaced 8-26-14. The activity supplies on the shelving in the cottage were removed on 8-07-14. All remaining sprinkler heads were check by the vendor for compliance. Maintenance supervisor/designee verified all areas did not impede the spray pattern of the sprinkler heads. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 12 residents had the potential to be affected by the corrosion and 25 residents had the potential to be affected by the obstructed spray. PIPE, Inc has installed the sprinkler head in the 600 hall overhang and activity supplies have been removed so that the sprinkler head spray is not obstructed. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Sprinkler heads will be observed internally by maintenance supervisor/designee according to the preventive maintenance schedule. Contracted service will also inspect entire building</p>	

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K010064 SS=D	<p>Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice could affect any of the 25 residents in the Cottage.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 08/07/14 at 12:37 p.m., activity supplies were stacked on the top shelf to within eight inches of the sprinkler head in the activity storage closet in the clean utility room of the Cottage. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure annual and monthly checks were provided for 1 of 1 portable fire extinguishers located in the east electrical room. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically</p>	K010064	<p>annually to ensure sprinkler heads are in reliable operating condition and unobstructed. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Environmental safety CQI tool will be completed quarterly and results will be reviewed at the appropriate monthly safety meeting.</p> <p>It is the practice of this provider to ensure annual and monthly checks are provided for portable fire extinguishers. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The portable extinguisher that lacked annual inspection evidence was removed and replaced with an extinguisher that had a valid</p>	08/08/2014

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K010130 SS=E	<p>indicated by a monthly inspection. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation and interview with the Maintenance Supervisor on 08/07/14 at 1:25 p.m., he acknowledged the annual service and inspection tag for the portable fire extinguisher located in the east electrical room was dated for October 2012 and lacked evidence of a annual inspection since that date.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 1. Based on observation and interview, the facility failed to ensure the</p>	K010130	<p>inspection tag on 8-8-15. All other fire extinguishers were observed by maintenance supervisor/designee and verified to have current inspection tags. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No residents had the potential to be affected but staff had the potential to be affected. An extinguisher with a valid inspection tag was placed in the east electrical room on 8-8-14 What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Maintenance supervisor did a complete building inventory of fire extinguishers. Contracted service billing will be compared to inventory to validate that all extinguishers are checked by comparing numbers on billing with number on inventory. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Environmental safety CQI tool will be completed quarterly and results will be reviewed at the appropriate monthly safety meeting.</p> <p>It is the practice of this provider to ensure penetration of fire barrier</p>	08/26/2014	

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	<p>penetration in 1 of 7 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect</p>		<p>walls is maintained to ensure the fire resistance of the barrier. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The sprinkler line penetrating the fire barrier wall in the 700 hall attic was sealed by the maintenance supervisor on 8-26-14. All sprinkler lines were inspected by the maintenance supervisor/designee to ensure no other unfilled penetrations to the fire barrier walls exist. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 25 residents could potentially be affected by the alleged deficient practice. Fire resistant caulking was used to fill the one half inch unsealed sprinkler line that penetrated the fire barrier. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Maintenance supervisor did building check to ensure there were not additional unsealed penetrations. Preventive maintenance will be scheduled quarterly to verify sealer is still intact and fire barriers are not compromised. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Environmental</p>	

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K010143 SS=E	<p>residents in 2 of 8 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 08/07/14 at 3:15 p.m., there was a one half inch unsealed penetration around the sprinkler line at the 700 hall fire barrier wall in the attic. Measurements were provided by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <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</p>	K010143	<p>safety CQI tool will be completed quarterly and results will be reviewed at the next scheduled monthly safety meeting.</p> <p>It is the practice of this provider to ensure that the areas used for</p>	08/26/2014	

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	<p>facility failed to ensure 1 of 1 areas used for transferring of oxygen was provided with continuous mechanical ventilation. This deficient practice could affect residents in 1 of 8 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 08/07/14 at 1:20 p.m., the mechanical ventilation in the oxygen transfilling/storage room which contained one large stationary container of liquid oxygen was not working. At the time of observation, the Maintenance Supervisor confirmed the oxygen room mechanical vent was not working.</p> <p>3.1-19(b)</p>		<p>transferring of oxygen was provided with continuous mechanical ventilation. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The defective ventilation fan motor was replaced 8-13-14. There are no additional oxygen transfer/storage rooms in the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 25 residents could potentially be affected by the alleged deficient practice. Maintenance supervisor replaced the defective ventilation fan motor on 8-13-14 What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Preventive maintenance schedule includes verifying that the ventilator fan in the transferring of oxygen area is working. Nursing staff has been reminded to alert maintenance supervisor immediately if it does not appear to be working properly. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Environmental safety CQI tool will be completed quarterly and results will be reviewed at the next scheduled monthly safety meeting.</p>		

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K010147 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 1 of 1 flexible cords was not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 08/07/14 at 12:00 p.m., a refrigerator was plugged into an extension cord power strip in the Medical Records office. The Maintenance Supervisor acknowledged the power strip and it was removed.</p> <p>3.1-19(b)</p>	K010147	<p>It is the practice of this provider to ensure that electrical wiring and equipment is in accordance with standards. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Power strip was removed immediately. Maintenance director/designee inspected entire building to ensure there were no refrigerators plugged into power strips. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No residents had the potential to be affected by the alleged deficient practice, only staff was potentially affected.. Maintenance supervisor removed the powerstrip immediately. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Maintenance supervisor/designee will implement preventive maintenance check for the proper use of power strips in the building quarterly and as appropriate. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Environmental safety CQI tool and Life Safety</p>	08/07/2014	

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			CQI tool will be completed as currently scheduled and results will be reviewed at the next scheduled monthly safety meeting.		