

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/12/2016
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NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 CROSS AVE MADISON, IN 47250
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/12/16</p> <p>Facility Number: 000116 Provider Number: 155209 AIM Number: 100266330</p> <p>At this Life Safety Code survey, The Waters of Clifty Falls 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 fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 138 and had a census of 92 at the time of this visit.</p>	K 0000	Preparation submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements We respe respectively ask gor paper compliance.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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K 0018 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has two detached wooden storage buildings which were not sprinkled.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure the 2 of 103 corridor room doors were provided with a suitable means for keeping the door closed or capable of resisting the passage of smoke. This deficient practice could affect 57 residents who reside on the</p>	K 0018	<p>Maintenance Director filled the two one quarter inch diameter holes in the top of the Canyon Hall nurses station shower room door with level 3 rated fire caulk Maintenance Director installed latching hardware to the storage room door on the administration hall</p>	03/13/2016

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K 0027 SS=E Bldg. 01	<p>Canyon Hall and any residents who use the Administration Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 02/12/16 during a tour of the facility from 9:45 a.m. to 1:50 p.m., the Canyon Hall nurses station shower room door had two, one quarter inch diameter holes in the top of the door. Furthermore, the Administration Hall forty square foot storage room door lacked latching hardware. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 02/12/16 at 2:10 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 4 of 7 sets of</p>	K 0027	<p>Maintenance Director conducted audits of all doors for missing hardware and holes on 2\29\16, no other missing hardware or holes were noted in any other doors Maintenance Director was inserviced by the Administrator on 2\28\16 related to Tag K 018 Audits of the doors for holes or missing hardware will be conducted monthly and results reported to the Quality Assurance Performance Improvement Committee</p> <p>The canyon north hall set of smoke barrier doors, the Service</p>	03/13/2016			

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	<p>smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on observations on 02/12/16 during a tour of the facility from 9:45 a.m. to 1:50 p.m. with the maintenance supervisor, the Canyon North Hall set of smoke barrier doors, the Service Hall smoke barrier door, the Administration Long Hall set of smoke barrier doors and the Administration Hall leading to the Creek Hall set of smoke barrier doors had between a one inch to two inch gap along the center where the doors came together in the closed position. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 02/12/16 at 2:10 p.m.</p> <p>3.1-19(b)</p>		<p>Hall smoke barrier door, the Administration Long Hall set of smoke barrier doors and the Administration Hall leading to the Creek Hall set of smoke barrier doors were repaired so that they provide a smoke barrier in compliance with NFPA 101 Life Safety Code standard K 027 Maintenance Director Audited all other Fire\smoke barrier doors and were found to be in compliance Maintenance Director was inserviced related to Tag 027 Maintenance Director will audit all fire doors monthly with results reported to the QAPI Committee</p>	

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K 0029 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 fuel fired equipment rooms was separated by smoke resistant partitions. This deficient practice could affect 48 residents who use the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 02/12/16 at 12:10 p.m. with the maintenance supervisor, the kitchen gas fired hot water heater room east wall had a four foot by two foot area of drywall missing and covered with a sheet of non rated plywood. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 02/12/16 at 2:10 p.m.</p> <p>3.1-19(b)</p>	K 0029	<p>Maintenance Director sealed the Kitchen gas fired hot water heater room east wall with drywall Maintenance Director audited the facility for other breaches of smoke resistant partitions Maintenance Director was inserviced on Tag K 029 by the Administrator Maintenance Director will audit facility monthly for breaches of smoke resistant partitions and report to QAPI</p>	03/13/2016

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K 0046 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 2 battery backup lights was tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect any residents in the event of a power outage and the fire alarm panel room battery backup lighting</p>	K 0046	<p>The Outside Emergency battery back up light at the emergency generator was tested for the annual ninety minute test on 2\26\16 by the Maintenance Director The battery backup light located in the fire alarm system room was tested for the annual ninety minute test on 2\26\16 by the Maintenance Director Maintenance Director was inserviced on tag K 046 by the administrator Maintenance Director to perform audits on the 2 Battery back up lights monthly and report results to QAPI</p>	03/13/2016
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	<p>was needed.</p> <p>Findings include:</p> <p>Based on record review on 02/12/16 at 10:20 a.m. with the maintenance supervisor, the Battery Operated Emergency Light Testing Log was reviewed and indicated the outside emergency battery backup light at the emergency generator was tested monthly and an annual ninety minute test was conducted within the past year. Based on observation on 02/12/16 at 11:40 a.m. with the maintenance supervisor, the fire alarm system room, located in the Administration Hall, had a battery backup light in use, which was listed on the Battery Operated Emergency Light Testing Log. Based on an interview with the maintenance supervisor on 02/12/16 at 11:40 a.m., it was stated the Battery Operated Emergency Light Testing Log did not list the fire alarm system room battery backup light and was not tested monthly or an annual ninety minute test was conducted over the past year. The lack of a monthly and annual ninety minute test conducted on the fire alarm system room battery backup light was verified by the maintenance supervisor at the time of interview and acknowledged by the administrator at the exit conference on 02/12/16 at 2:10 p.m.</p>			
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K 0062 SS=E Bldg. 01	<p>3.1-19(b)</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>Based on observation and interview, the facility failed to replace 2 of over 300 sprinklers in the facility covered in corrosion. 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 12 residents who reside on the Creek Hall and would use the front exit during an evacuation.</p> <p>Findings include:</p> <p>Based on observations on 02/12/16 during a tour of the facility with the maintenance supervisor from 9:45 a.m. to 1:50 p.m., the Service Hall boiler room sprinkler on the back west part of the room and the front entrance foyer</p>	K 0062	<p>Safecare replaced the Service Hall boiler room sprinkler on the back west part of the room</p> <p>Safecare replaced the front entrance foyer sprinkler</p> <p>Maintenance Director was inserviced on tag k 062 by the administrator</p> <p>Maintenance Director audited all sprinkler heads in the facility for corrosion</p> <p>Maintenance Director to perform audits monthly and report results to QAPI</p>	03/13/2016

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K 0066 SS=E Bldg. 01	<p>sprinkler were both covered in green corrosion. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 02/12/16 at 2:10 p.m.</p> <p>3.1-19(b)</p> <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 Based on observation, record review, and interview, the facility failed to ensure 3 of 3 areas where smoking was permitted used a noncombustible ashtray and metal self closing containers for discarded</p>	K 0066	The Maintenance Director placed a self closing Metal container outside the 200 hall smoking location and removed Cigarette butts from the ground surface The Maintenance Director	03/13/2016			

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K 0070 SS=E Bldg. 01	<p>smoking material. This deficient practice could affect all residents if a fire occurred at the outside locations where smoking is permitted.</p> <p>Findings include:</p> <p>Based on observations on 02/12/16 during a tour of the facility from 9:45 a.m. to 1:50 p.m. with the maintenance supervisor, the 200 Hall smoking location outside the exit door lacked a noncombustible ashtray and had thirty discarded cigarette butts on the ground surface, the outside side entrance smoking location had thirty five cigarette butts on the ground surface and under the emergency generator liquid petroleum gas tank, and the front entrance smoking location had twenty cigarette butts on the ground surface mixed with wooden mulch. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 02/12/16 at 2:10 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas</p>		<p>removed all Cigarette butts from the ground surface outside side entrance and the front entrance to the building The Maintenance Director was inserviced related to tag K 066, along with all staff related to the smoking Policy The Maintenance Director checked all outside perimeter of building for Cigarette Butts The Maintenance Director will audit weekly for proper use of Ashtrays and Cigarette butts on the ground surface and report the QAPI</p>		

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K 0072 SS=E Bldg. 01	<p>where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 portable space heating device was prohibited in an area other than a staff area. This deficient practice could affect 57 residents who reside on the Canyon Hall.</p> <p>Findings include:</p> <p>Based on observation on 02/12/16 at 9:55 a.m. with the maintenance supervisor, the Canyon Hall center nurses station opening to the corridor had a fake fire place with a portable electric space heating device in use and in the on position with heat coming from the heating vent.</p> <p>This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 02/12/16 at 2:10 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be 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 shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with</p>	K 0070	<p>The Maintenance Director removed fake fireplace with portable space heater</p> <p>The Maintenance Director audited facility for any other portable space heaters</p> <p>The Maintenance Director was inserviced by the administrator related to Tag k 070</p> <p>The Maintenance Director will audit the facility for space heaters monthly and results reported to QAPI</p>	03/13/2016

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	<p>7.1.10. 18.2.1, 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 5 of 8 corridor means of egress were continuously maintained free of obstructions. This deficient practice affects 57 residents who reside on the Canyon Halls.</p> <p>Findings include:</p> <p>Based on an observations with the maintenance supervisor on 02/12/16 at 9:50 a.m., the Canyon North Hall, Canyon South Hall, Canyon East Hall and Canyon West Hall had six plastic resident treatment carts, three hoyer lifts, eight wheelchairs, and two wooden chairs stored in the corridors. Furthermore, the Service Hall corridor had twelve boxes of nursing supplies and two metal racks of clothing stored in the corridor. Based on an interview with the maintenance supervisor on 02/12/16 at 10:30 a.m., the facility uses the corridor to store hoyer lifts, plastic resident treatment carts, and resident wheel chairs on a routine basis and there is not enough storage rooms to remove these items from the corridors. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 02/12/16 at 2:10 p.m.</p> <p>3.1-19(b)</p>			K 0072	<p>The facility will maintain a means of egress and facility corridors will remain free of obstructions The boxes of Nursing Supplies and the Metal racks of clothing were removed from the Service hallway Hoyer Lifts will be stored in the shower rooms, wheelchairs will be stored in the rooms in which they belong Administrator, Environmental Supervisor and Maintenance Director completed audit of facility for appropriate means of egress throughout facility Dept leaders will audit for means of egress daily x 4 weeks, 3 x week x 4 weeks weekly x 4 weeks then monthly x 6 months results reported in QAPI</p>		03/13/2016

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K 0074 SS=B Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13</p> <p>o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2.</p> <p>o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3</p> <p>o Newly introduced upholstered furniture and mattresses means purchased since March, 2003.</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 2 of 2 Service Hall rooms were flame retardant. This deficient practice could affect staff who work in the Service Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 02/12/16 at</p>	K 0074	<p>The Curtains in the Service Hall Conference room were removed The Maintenance Director audited all curtains in facility for Curtains that were not flame retardant or had not been sprayed with flame retardant spray Maintenance Director was inserviced by administrator related to tag K 074 The dept leaders will audit all curtains weekly for 3 months then monthly x 6 months and results</p>	03/13/2016
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/12/2016
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NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 CROSS AVE MADISON, IN 47250
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K 0130 SS=E Bldg. 01	<p>9:50 a.m., the Service Hall conference room had two sets of window curtains and the Service Hall housekeeping supervisor office had one set of window curtains which lacked attached documentation they were inherently flame retardant. Based on interview at the time of observations with the maintenance supervisor, there was no documentation regarding flame retardant window curtains for the Service Hall conference room and housekeeping supervisor office. This was acknowledged by the administrator at the exit conference on 02/12/16 at 2:10 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation, interview and record review; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire door was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical</p>	K 0130	<p>reported in QAPI</p> <p>1. Annual Rolling Fire Door Inspection scheduled with Safecare Maintenance Director Inserved by the Administrator related to K 130 Maintenance Director will audit Rolling Fire Door monthly to monitor if working appropriately and inspection is up to date results to QAPI 2 two boilers and water heater certificates were outdated, called chubb and inspections were currently up to date, ordered new certificates Maintenance Director to audit all boilers and hot water heaters monthly for up to date inspections, results</p>	03/13/2016

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	<p>sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 36 residents who use the main dining room in the East building.</p> <p>Findings include:</p> <p>Based on record review and interview on 02/12/16 at 9:45 a.m. with the maintenance supervisor, the maintenance supervisor indicated there was a rolling fire door protecting the opening from the kitchen to the corridor in the main dining room. Based on record review with the maintenance supervisor on 02/12/16 from 9:45 a.m. to 10:40 a.m., there was no record of an annual rolling fire door inspection for the kitchen rolling fire door. Based on observation during a tour of the kitchen on 02/12/16 at 11:50 a.m., the kitchen rolling fire door did not have an attached inspection tag indicating the last annual rolling fire door inspection was conducted. The lack of an annual kitchen rolling fire door inspection was verified by the maintenance supervisor at the time of interview and acknowledged</p>		reported to QAPI		

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	<p>by the administrator at the exit conference on 02/12/16 at 2:10 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 2 of 2 boilers had inspection certificates that were current to ensure the boilers were in safe operating condition. NFPA 101, in 19.1.1.3 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 36 resident who use the main dining room, located adjacent to the kitchen and staff who work in the Service Hall.</p> <p>Findings include:</p> <p>Based on review of the two A O Smith model hot water heaters inspection certificates with the maintenance supervisor on 02/12/16 at 9:55 a.m., the inspection certificates had an expiration date of 04/12/15. Based on an interview with the maintenance supervisor on 02/12/16 at 10:20 a.m., it was stated there are no current two year inspection certificates for the two A O Smith model hot water heaters. The lack of current inspection certificates for the two hot water heaters was acknowledged by the</p>			

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K 0143 SS=B Bldg. 01	<p>administrator at the exit conference on 02/12/16 at 2:10 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</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; and</p> <p>(b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.</p> <p>8-6.2.5.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer location was provided with a sign indicated the transferring of oxygen was occurring in the oxygen storage room. This deficient practice affects staff only and does not affect any residents because the oxygen storage room was located outside the Service Hall exit, which is a staff only location.</p>	K 0143	<p>Sign ordered for the Transfer Oxygen storage room indicating transferring taking place Maintenance Director inserviced by Administrator related to K 0143 Maintenance Director audited facility to ensure all areas with oxygen had appropriate signage Maintenance Director and Dept leaders to audit monthly x 6 months for appropriate signage with use of oxygen and transfil station</p>	03/13/2016	

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	<p>Findings include:</p> <p>Based on observation on 02/12/16 at 10:50 a.m. with the maintenance supervisor, the Service Hall outside oxygen storage room, where nine full liquid oxygen containers were stored, lacked a sign indicating the transferring of oxygen occurred in the oxygen storage location. Based on an interview with the administrator on 02/12/16 at 2:00 p.m., it was stated the nursing staff transfers oxygen from the large containers to small portable containers in the liquid oxygen storage room for resident use. The lack of a sign indicating the transferring of oxygen occurs at the Service Hall outside oxygen storage was acknowledged by the administrator at the exit conference on 02/12/16 at 2:10 p.m.</p> <p>3.1-19(b)</p>				