

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155103	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/20/2015
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NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614
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K 000 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: 04/20/2015</p> <p>Facility Number: 000042 Provider Number: 155103 AIM Number: 100291540</p> <p>At this Life Safety Code survey, Ironwood Health and Rehabilitation 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 V (111) construction and was fully sprinklered with the exception of the rear entrance canopy. The facility has a fire alarm system with smoke detection the corridors, areas open to the corridors, and battery operated smoke detectors in the resident sleeping rooms. The facility</p>	K 000	Preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth or facts alleged or conclusion set forth in this Statement of Deficiencies. The Plan or Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. Ironwood Health and Rehabilitation Center desires that this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective May 20, 2015.	

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 018 SS=D Bldg. 01	<p>has a capacity of 183 with a census of 98 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered except for the rear entrance canopy. All areas providing facility services were sprinklered except for a detached laundry building, maintenance shed and a storage shed.</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 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 96 resident room corridor doors closed and latched into the door frame. This deficient practice could affect 2 residents.</p>	K 018	<p>K 018 The corridor door to resident room 410 was fixed on 5/7/15 and now closes and latches into the frame. All 96 doors were inspected on 5/14/15 and found to be in good working order..</p>	05/14/2015

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K 021 SS=D Bldg. 01	<p>Findings include:</p> <p>Based on observation and interview on 04/20/15 at 11:02 a.m., the Maintenance Supervisor acknowledged the corridor door to resident room 410 failed to close and latch into the door frame when tested.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p>		<p>The Maintenance Director and Assistant were in-serviced 5/12/15 on inspecting resident room doors during routine rounds to ensure all doors latch into their frames. The Maintenance Director and/or Assistant will log any identified concerns and will follow up immediately to ensure compliance is maintained. The Administrator/Designee will review completed logs monthly to ensure any needed follow up has been completed.</p> <p>The rounding logs completed by the Maintenance Director and/or Assistant will be reviewed by the Administrator/Designee, will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow up.</p> <p>Completion Date: May 14, 2015</p>		

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	<p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 rooms exceeding 50 square feet and storing combustible materials on the 500 Hall, which is a hazardous area, was provided with self closer and would latch into the frame. This deficient practice was not in a resident care but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation on 04/20/15 at 11:48 a.m., the 500 Hall Ancillary Room door was propped open with a piece of cardboard. Inside the room contained storage of cardboard, underwear, and bottles of hand sanitizer. Based on interview, the Maintenance Supervisor acknowledged the size of the room and the amount of hazardous material in a room open to the corridor and removed the piece of cardboard allowing the door to automatically close and latch.</p> <p>3.1-19(b)</p>	K 021	<p>K 021</p> <p>The piece of cardboard that was used to prop open the door to the 500 hall Ancillary room door was removed on 4/20/15.</p> <p>The Ancillary staff and Maintenance staff was in-serviced on 5/12/15 that no facility doors with self closures or contain hazards will be propped open.</p> <p>The Maintenance Director and/or Assistant will log any identified concerns during routine rounds and will follow up immediately to ensure compliance is maintained. The Administrator/Designee will review completed logs monthly to ensure any needed follow up has been completed.</p> <p>The rounding logs completed by the Maintenance Director and/or Assistant that will be reviewed by the Administrator/Designee, will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow up.</p> <p>Completion date: 4/20/15</p>	04/20/2015

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K 025 SS=F Bldg. 01	<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 the penetrations caused by the passage of wire and/or conduit through 6 of 13 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect four of thirteen smoke compartments.</p>	K 025	<p>K 025 The Maintenance Director has repaired the fire wall penetrations. The repairs were made in the following locations on 5/8/15: A. 100 Hall Day room Water Heater Room B. 400 Hall Mechanical room C. Nursing room in the 400 Hall D. Room 423 closet E. Medication room in 500 Hall F. Mechanical room in 500 Hall G. Room 524 H. Room 525 I. Room 529 J. 100 Hall Day room Water Heater Room (listed twice) The Maintenance Director and Assistant have been in-serviced that identified exposed penetrations are to be logged on the routine maintenance rounding logs and repaired immediately to ensure that continued compliance is maintained. The Maintenance Director and/or</p>	05/08/2015
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	<p>Findings include:</p> <p>Based on an observation during the tour with the Maintenance Supervisor on 04/20/15 between 11:18 a.m. and 3:12 p.m., the following fire wall penetrations were discovered:</p> <p>A. Eight inch by ten inch size of drywall was missing in the 100 Hall Day Room Water Heater Room</p> <p>B. Fire caulk was pulled away from ceiling in the 400 Hall mechanical room. 1 of 7 ceiling penetrations gaps sized 3/8 inch around water pipe.</p> <p>C. Ceiling penetration around conduit in the Nursing room in the 400 Hall</p> <p>D. There was a one inch ceiling penetration in resident room 423 closet affecting two residents.</p> <p>E. There was a 1/4 inch ceiling penetration in Medication Room in the 500 Hall.</p> <p>F. There was a 1/4 inch ceiling penetration in Mechanical Room in the 500 Hall.</p> <p>G. There was a 1/2 inch ceiling penetration in resident room 524 around sprinkler line support affecting staff only.</p> <p>H. There was a 1/4 inch ceiling penetration in resident room 525 affecting staff only.</p> <p>I. One 1/4 inch and one 1 1/2 inch ceiling penetration in resident room 529</p> <p>J. Eight inch by ten inch size of drywall</p>		<p>Assistant will log any identified concerns during routine rounds and will follow up immediately to ensure compliance is maintained. The Administrator/Designee will review completed logs monthly to ensure any needed follow up has been completed.</p> <p>The rounding logs completed by the Maintenance Director and/or Assistant that will be reviewed by the Administrator/Designee, will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow up.</p> <p>Completion Date: 5/8/15</p>	

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K 029 SS=D Bldg. 01	<p>was missing in the 100 Hall Day Room Water Heater Room.</p> <p>Based on interview, the aforementioned conditions were acknowledged by the Maintenance Supervisor the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the 1 of 1 corridor doors to the fuel-fired water heater room on the 100 Hall, a hazardous area, was provided with self closer and would latch into the frame. This deficient practice could affect at least 2 residents.</p> <p>Findings include:</p> <p>Based on observation on 04/20/15 at 2:09 p.m., the 100 Hall Water Heater Room</p>	K 029	<p>K 029</p> <p>The 100 Hall Water Heater room door now has a positive latching device as well as a self closing device that was installed on 5/13 /15.</p> <p>The Maintenance Director and Assistant were in-serviced on 5/12/15 that the facility doors are to be checked during routine rounds to ensure that the doors properly latch and are fitted with a working door closer.</p> <p>The Maintenance Director and/or Assistant will log any identified</p>	05/13/2015

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K 038 SS=E Bldg. 01	<p>door was not provided with a positive latching device and did not have a self closing device. Based on interview, the Maintenance Supervisor acknowledged the 100 Hall Water Heater Room door needed to be self closing and have positive latching capabilities.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 3 400 Hall exits were readily accessible at all times. This deficient practice could affect all residents, staff, and visitors in the 400 Hall.</p> <p>Findings include:</p> <p>Based on observation and interview with the Maintenance Supervisor on 04/20/15 at 11:40 a.m., the exit door in the 400</p>	K 038	<p>concerns during routine rounds and will follow up immediately to ensure compliance is maintained. The Administrator/Designee will review completed logs monthly to ensure any needed follow up has been completed.</p> <p>The rounding logs completed by the Maintenance Director and/or Assistant that will be reviewed by the Administrator/Designee, will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow up. Completion Date 5/13/15</p> <p>K 038</p> <p>1. The exit door in the 400 Hall electromagnetic locks has been serviced and is in good working condition. The door now properly releases after 15 second delay when pressure is applied. Correction made on 4/23/15</p> <p>2. The exit door in the Main Dining Hall has been serviced and is in good working condition. The door now properly releases after 15 second delay when pressure is applied. Correction made on</p>	05/14/2015

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	<p>Hall was equipped with electromagnetic locks that released after pushing the door for 15 seconds. When the exit door was tested, the Maintenance Supervisor had to use excessive force to get the door to open. The Maintenance Supervisor acknowledged the door was difficult to open.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 4 Main Dining Room exits were readily accessible at all times. This deficient practice could affect all residents, staff, and visitors in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation and interview with the Maintenance Supervisor on 04/20/15 at 2:23 p.m., the exit door leading outside in the Main Dining Hall was equipped with electromagnetic locks that released after pushing the door for 15 seconds. When the exit door was tested, the door failed to open. The Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview,</p>		<p>4/23/15</p> <p>3. The sidewalk cement exiting the 500 Hall was leveled on 5/14 /15 to ensure there is no drop or potential for a tripping hazard. The Maintenance Director and Assistant were in-serviced on 5/12/15 that facility exit doors will be checked on a routine basis for proper working order as well as routinely checking sidewalks for drops not level. The Maintenance Director will ensure that all exit doors with a releasing device are tested quarterly by the Fire Safety contractor and will properly release when pressure is applied within 15 seconds.</p> <p>The Maintenance Director and/or Assistant will log any identified concerns with the door releases and sidewalks during routine weekly rounds and will follow up immediately to ensure compliance is maintained. The Administrator/Designee will review completed logs monthly to ensure any needed follow up has been completed.</p> <p>The rounding logs completed by the Maintenance Director and/or Assistant that will be reviewed by the Administrator/Designee, will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is maintained. The QA Committee will make recommendations for needed</p>		

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K 044 SS=E Bldg. 01	<p>the facility failed to provide an exit discharge readily accessible for 1 of 3 means of egress to a public way in the 500 Hall. LSC Section 19.2, Means of Egress Requirements, requires every exit discharge, exit location and access shall be in accordance with LSC Chapter 7. LSC 7.1.6.3 requires the means of egress be nominally level. This deficient practice affects all residents, staff, and visitors that would evacuate through the 500 Hall exit in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation on 4/20/15 at 12:40 p.m., the sidewalk exiting in the 500 Hall dropped two inches when discharging to a public way. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the measurement of the sidewalk drop and the potential of a tripping hazard.</p> <p>3.1-19(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>	K 044	<p>changes and/or follow up. Completion date: May 14, 2015</p> <p>K 044</p>	05/20/2015	

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	<p>facility failed to ensure 2 of 13 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice could affect staff only in the 500 Hall and up to 18 residents in the 400 hall.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Maintenance Supervisor on 04/20/15 at 11:50 a.m. and 12:11 p.m., there was a two hour fire wall separating the 400 Hall and 500 Hall. When tested the doors failed to latch through four attempts. The next set of two hour fire walls separating the 500 Hall also failed to latch through two attempts. Based on interview at the time of observations, the Maintenance Supervisor acknowledged the doors were not latching into the frame.</p>		<p>The 2 hour fire door separating the 400 hall and 500 halls has been serviced and now latches into the frames. The next set of 2 hour fire doors on 500 Hall has been serviced and now latches into the frame. The Maintenance Director and Assistant have been in-serviced 5/12/15 on ensuring the fire doors latch into the frames when released. The Maintenance Director will ensure that all fire doors are tested monthly to ensure they latch properly into the frame. All fire doors were audited to ensure latching into the frames. The Maintenance Director and/or Assistant will log any identified concerns with the door latches during routine weekly rounds and will follow up immediately to ensure compliance is maintained. The Administrator/Designee will review completed logs monthly to ensure any needed follow up has been completed.</p> <p>The rounding logs completed by the Maintenance Director and/or Assistant that will be reviewed by the Administrator/Designee, will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow up.</p> <p>Completed date: May 20, 2015</p>	

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K 046 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to provide exterior emergency lighting for 1 of 3 500 Hall exits. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect 500 Hall occupants evacuated through the exit.</p> <p>Findings include:</p> <p>Based on observation and interview on 4/20/15 at 12:38 p.m., the Maintenance Supervisor acknowledged the lack of an exterior light fixture exiting the 500 Hall to provide the entire exit discharge with illumination.</p> <p>3.1-19(b)</p>	K 046	<p>K 046</p> <p>An exterior light fixture exiting the 500 Hall has been installed to provide the entire exit discharge with illumination.</p> <p>The Maintenance Director and Assistant were in-serviced 5/12/15 on ensuring lighting for means of egress is present.</p> <p>The Maintenance Director and/or Assistant will log any identified concerns during routine rounds and will follow up immediately to ensure compliance is maintained. The Administrator/Designee will review completed logs monthly to ensure any needed follow up has been completed.</p> <p>The rounding logs completed by the Maintenance Director and/or Assistant that will be reviewed by the Administrator/Designee, will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow up.</p>	05/20/2015	

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K 050 SS=F Bldg. 01	<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 7 of 8 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on record review of "Fire Drill Reports" on 04/20/15 at 9:42 a.m. with the Maintenance Supervisor, the documentation for the drills performed between the hours of 6:00 a.m. and 9:00</p>	K 050	<p>Completion date: 5/20/15</p> <p>K 050 The fire alarm system is receivable by the monitoring company after activation and is monitored 24 hours a day. Verification of the transmission of signal is now being documented when conducting fire drills. The Maintenance Director and Assistant were in-serviced on 5/12/15 regarding documentation verifying the signal was received by the monitoring company. After each fire drill, Maintenance Director will call the monitoring company to verify the signal was received and document the time. The monitoring company will fax or email a confirmation the signal was received. The documentation will then be filed in the Maintenance Fire drill binder monthly. The Maintenance Director and/or Assistant will log any identified concerns during routine fire drills</p>	05/20/2015

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K 051 SS=D Bldg. 01	<p>p.m. for the past twelve months lacked verification of the transmission of the signal for drills conducted on 1/31/15, 10:10 a.m.; 2/28/15, 7:56 p.m.; 5/30/14, 1:30 p.m., 6/30/14, 2:10 p.m.; 7/30/14, 12:40 p.m.; 8/26/14 7:40 p.m.; 11/25/14, 11:38 a.m. Based on interview at the time of record review, the Maintenance Supervisor said he calls to confirm that the monitoring company receives the alarm, but does not document the time given.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily</p>		<p>regarding receipt of signal and will follow up immediately to ensure compliance is maintained. The Administrator/Designee will review completed logs monthly and verifications to ensure any needed follow up has been completed. The Fire Drill logs completed by the Maintenance Director and/or Assistant that will be reviewed by the Administrator/Designee, will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow up. Completion date: 5/20/15</p>	

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K 052 SS=F Bldg. 01	<p>available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 400 Hall and 1 of 3 500 Hall manual fire alarm boxes was mounted at the proper height. NFPA 72, The National Fire Alarm Code, 2-8.1 states the operable part of each manual fire alarm box shall be not less the forty two inches and not more than fifty four inches from the floor level. This deficient practice affects 41 residents in 400 Hall and staff only in 500 Hall.</p> <p>Findings include:</p> <p>Based on observation and interview on 04/20/15 at 11:27 a.m. and 11:52 a.m., the Maintenance Supervisor measured and confirmed that both manual fire alarm boxes operable part was mounted sixty inches from the floor.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical</p>	K 051	<p>K 051</p> <p>The 400 Hall and 500 Hall manual fire alarm boxes have been lowered to the proper height.</p> <p>A facility wide audit was completed and all fire alarm boxes that were found to be noncompliant with regulation standard height were lowered to proper height.</p> <p>Completion date 5/20/15</p> <p>The Maintenance Director and/or Assistant will log any identified concerns during routine rounds and will follow up immediately to ensure compliance is maintained. The Administrator/Designee will review completed logs monthly to ensure any needed follow up has been completed.</p> <p>The rounding logs completed by the Maintenance Director and/or Assistant that will be reviewed by the Administrator/Designee, will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow up.</p>	05/20/2015

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	<p>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 record review and interview, the facility failed to ensure 88 of 88 smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <p>(1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument</p>	K 052	<p>K 052</p> <p>Sensitivity testing on all smoke detectors has been completed. Any smoke detectors not meeting standard was documented to replace or was replaced. The Maintenance Director will maintain records of all sensitivity testing completed by the Fire Safety contractor in the Preventative Maintenance record log. Administrator/Designee will review the Preventative Maintenance records monthly to ensure timely records and any needed follow up has been completed. The PM logs completed by the Maintenance Director and/or Assistant that will be reviewed by the Administrator/Designee, will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow up. Completion Date: 5/20/15</p>	05/20/2015

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K 062 SS=F Bldg. 01	<p>(3) Listed control equipment arranged for the purpose</p> <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</p> <p>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor on 04/20/15 at 10:07 a.m., the most recent documentation of a smoke detector sensitivity test was dated 11/5/12. Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are</p>			

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	<p>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 record review and interview, the facility failed to ensure the sprinkler system components was inspected 2 of 4 most recent calendar quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, all staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on sprinkler system record review with the Maintenance Supervisor on 04/20/15 at 10:22 a.m., there was no second quarter (January, February, March) or fourth quarter (October, November, December) of 2014 sprinkler system inspection reports available. Based on interview with the Maintenance</p>	K 062	<p>K 62</p> <p>The sprinkler system was inspected on 1/21/15 and again on 4/20/15. The Maintenance Director and Assistant were in-serviced on when the sprinkler inspections need to occur. The Maintenance Director and the Administrator now has a calendar to ensure timely scheduling of all inspections.</p> <p>The Administrator/designee will review inspection calendar monthly to ensure timeliness of inspections. The Maintenance Director and/or Assistant will log any identified concerns during the quarterly inspections by the Fire Safety contractor and will follow up immediately to ensure compliance is maintained. The Administrator/Designee will review completed inspections to ensure any needed follow up has been completed.</p> <p>The inspections completed by the Fire Safety contractor that will be reviewed by the Administrator/Designee, will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) each quarter to ensure timely compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow up. Completion Date: 5/20/15</p>	05/20/2015			

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K 064 SS=D Bldg. 01	<p>Supervisor during record review, he indicated there was no written documentation or other evidence the sprinkler system had been inspected during the second and fourth quarter of 2014.</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</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguisher in 100 Hall pressure gauge readings was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect at least 4 residents and staff in the 100 Hall.</p> <p>Findings include:</p>	K 064	<p>K 064</p> <p>1. The portable fire extinguisher on 100 Hall was replaced on 4/24/15.</p> <p>2. The portable fire extinguisher in Therapy room was replaced on 4/24/15.</p> <p>A facility wide audit was completed by the Maintenance Director and found no other extinguishers to be over charged or not meeting NFPA standards.</p> <p>The Maintenance Director and/or Assistant will log any identified concerns during routine fire extinguisher inspections monthly and will follow up immediately to ensure compliance is maintained by replacing or charging those not found compliant. The Administrator/Designee will review</p>	04/24/2015

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	<p>Based on observation and interview with the Maintenance Supervisor during a tour of the facility on 04/20/15 at 12:17 p.m., the gauge on the portable fire extinguisher located in the 100 Hall indicated the extinguisher was overcharged. The Maintenance Supervisor agreed at the time of observation, the gauge reading was not in the normal operating range.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the Therapy room pressure gauge readings was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect at least 10 residents and staff in the Therapy room.</p> <p>Findings include:</p> <p>Based on observation and interview with the Maintenance Supervisor during a tour</p>		<p>completed logs monthly to ensure any needed follow up has been completed.</p> <p>The preventative maintenance logs completed by the Maintenance Director and/or Assistant that will be reviewed monthly by the Administrator/Designee, and will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow up.</p> <p>Completion date: 4/24/15</p>	

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K 066 SS=E Bldg. 01	<p>of the facility on 04/20/15 at 12:32 p.m., the gauge on the portable fire extinguisher located in the Therapy room indicated the extinguisher was overcharged. The Maintenance Supervisor agreed at the time of observation, the gauge reading was not in the normal operating range.</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</p>			

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	<p>Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for staff and residents were maintained and the metal container with a self-closing cover was used for an ashtray. This deficient practice could affect at least 13 residents and facility staff who smoke cigarettes.</p> <p>Findings include:</p> <p>Based on observations and interview with the Maintenance Supervisor on 01/27/15 between 10:58 a.m. and 2:31 p.m. the following was discovered:</p> <p>A. Employee smoking area cigarette butts were discovered outside the exit door from the laundry room.</p> <p>B. Former smoking area near 100 day room court yard at least 100 cigarette butts were on the ground.</p> <p>C. Resident smoking area had at least 30 cigarette butts on the ground.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged the location and the number of cigarette butts at the aforementioned areas.</p> <p>3.1-19(b)</p>	K 066	<p>K 066</p> <p>A. The cigarette butts outside the exit door from the laundry room were cleaned up.</p> <p>B. The cigarette butts outside the 100 Hall day room were cleaned up.</p> <p>C. The cigarette butts on the ground in the resident smoking area were cleaned up.</p> <p>All staff was in-serviced on keeping the smoke areas clean and free of cigarette butts. They were in-serviced on where the proper smoke areas are as well as where to dispose of the butts. These areas will be monitored for non compliance and non compliant staff will be held accountable for improper disposal of cigarette butts including written counseling's up to terminations. The Maintenance Director and/or Assistant will log any identified concerns during weekly routine rounds and will follow up immediately to ensure compliance is maintained. The Administrator/Designee will review completed logs monthly to ensure any needed follow up has been completed.</p> <p>The logs completed by the Maintenance Director and/or Assistant that will be reviewed monthly by the Administrator/Designee, and will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is</p>	05/19/2015	

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K 067 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on interview, the facility failed to ensure an undetermined number of dampers in the ductwork at smoke barriers and fire barriers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A to protect 98 of 98 residents. LSC 19.5.2.1 refers to Section 9.2. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary.</p> <p>This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p>	K 067	<p>maintained. The QA Committee will make recommendations for needed changes and/or follow up. Completion date: 5/19/15</p> <p>K067</p> <p>The smoke dampers have been inspected.</p> <p>The Maintenance Director and Assistant were in-serviced and will maintain records of all smoke dampers completed by the Fire Safety contractor in the Preventative Maintenance record log.</p> <p>Administrator/Designee will review the Preventative Maintenance records monthly to ensure timely records and any needed follow up has been completed.</p> <p>The PM logs completed by the Maintenance Director and/or Assistant that will be reviewed by the Administrator/Designee, will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow up. Completion Date: 5/20/15</p>	05/20/2015

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K 130 SS=F Bldg. 01	<p>Based on interview between 9:20 a.m. to 10:51 a.m. on 4/20/15, the Maintenance Supervisor was asked if the facility had smoke dampers. He confirmed that there were smoke dampers. Based on record review, the Maintenance Supervisor was unable to provide documentation to facility smoke dampers had been inspected.</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1) Based on observation and interview, the facility failed to ensure the penetration in 1 of 11 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: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance</p>	K 130	<p>K 130</p> <p>1.</p> <p>A. The attic fire wall penetration near resident room 312 was corrected on 5/13/15</p> <p>B. The drywall tape missing off the attic fire wall near resident room 312 was corrected on 5/13 /15</p> <p>C. The vent in 200 hall Dining room is now closed to the attic, corrected on 5/13/15</p> <p>D. The penetration found sealed with expandable foam near resident room 412 that had no documentation has been corrected on 5/13/15</p> <p>E. The penetration where attic access board was removed near resident room 425 was corrected on 5/13 /15</p> <p>F. The 3 separate penetrations in attic smoke barrier wall in the 500</p>	05/20/2015

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	<p>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 residents in 6 of 13 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation during the tour with the Maintenance Supervisor on 04/20/15 between 11:18 a.m. and 3:12 p.m., the following fire wall penetrations were discovered:</p> <p>A. There was a 3/4 inch penetration with two black wires passing through the attic fire wall near resident room 312.</p> <p>B. Drywall tape is missing causing drywall to separate off the attic fire wall near resident room 312.</p> <p>C. Eight inch vent in 200 Hall Dining</p>		<p>Hall was corrected on 5/13 /15</p> <p>The Maintenance Director and Assistant have been in-serviced that identified exposed penetrations in the attic are to be logged on the routine maintenance rounding logs monthly and repaired immediately to ensure that continued compliance is maintained.</p> <p>The Maintenance Director and/or Assistant will log any identified concerns during routine rounds monthly and will follow up immediately to ensure compliance is maintained. The Administrator/Designee will review completed logs monthly to ensure any needed follow up has been completed.</p> <p>The rounding logs completed by the Maintenance Director and/or Assistant that will be reviewed by the Administrator/Designee, will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow up.</p> <p>2.</p> <p>The battery operated smoke detector preventative maintenance program was updated to include when the battery was changed and what room. The program includes documentation for weekly inspection.</p> <p>The Maintenance Supervisor</p>				

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	<p>Room is open to the attic.</p> <p>D. No documentation provided for the penetrations sealed with expandable foam in the 400 Hall attic near resident room 412.</p> <p>E. There was a two foot by three foot penetration where attic access board was removed near resident room 425.</p> <p>F. Three separate one and one quarter inch penetration in attic smoke barrier wall in the 500 hall.</p> <p>Based on interview, the Maintenance Supervisor acknowledged each penetration at the time of each observation.</p> <p>3.1-19(b)</p> <p>2) Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 96 of 96 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents and visitors throughout the facility.</p> <p>Findings include:</p>		<p>inspected all battery operated smoke detectors on 5/19 /15 to ensure good working condition and no batteries needed replaced. The Maintenance supervisor was in-serviced on 5/12/15 that all facility battery operated smoke detectors will be inspected on a weekly basis and that the inspections will detail the location, date and operability of each smoke detector.</p> <p>The Maintenance Director and/or Assistant will log any identified concerns during routine rounds weekly and will follow up immediately to ensure compliance is maintained. The Administrator/Designee will review completed logs monthly to ensure any needed follow up has been completed.</p> <p>The rounding logs completed by the Maintenance Director and/or Assistant that will be reviewed monthly by the Administrator/Designee, will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow up.</p> <p>3.</p> <p>The 100 Hall exit door was previously identified as needing replaced and was on order at time of survey. The door was on order in</p>				

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	<p>Based on review of the floor plan of the facility and "Inspection and Testing Certificate" with the Maintenance Supervisor on 04/20/15 at 9:22 a.m., resident battery operated smoke alarm testing form "Inspection and Testing Certificate" did not include information about battery replacement. Based on interview at the time of record review, the Maintenance Supervisor stated he changes smoke alarm batteries when they need changing but does not document the room or date. No additional battery operated smoke alarm testing documentation was available for review.</p> <p>3.1-19(a)</p> <p>3) Based on observation and interview, the facility failed to ensure 1 of 3 100 Hall exits was properly maintained. LSC 19.7.3 requires proper maintenance shall be provided to ensure the dependability of the method of evacuation selected. This deficient practice could affect all residents, staff, and visitors in the 100 Hall.</p> <p>Findings include:</p> <p>Based on observation and interview with the Maintenance Supervisor on 04/20/15 at 12:18 p.m., the 100 Hall exit door</p>		<p>April 2015 and installed on 5/1/15 when received.</p> <p>The Maintenance Director and/or Assistant will continue to log any identified concerns during routine rounds weekly and will follow up immediately to ensure compliance is maintained. The Administrator/Designee will review completed logs monthly to ensure any needed follow up has been completed.</p> <p>The rounding logs completed by the Maintenance Director and/or Assistant that will be reviewed monthly by the Administrator/Designee, will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow up.</p> <p>Completion date: 5/20/15</p>	

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K 143 SS=D Bldg. 01	<p>crash bar was broken on the right side and hanging down unsupported. When the exit door was tested, the door opened. The Maintenance Supervisor acknowledged the broken handle.</p> <p>3.1-19(a) 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 facility failed to ensure 1 of 1 liquid oxygen storage areas where oxygen transferring takes place, was provided with continuous mechanical ventilation.</p>	K 143	<p>K 143</p> <p>The switch to the fan/vent in the oxygen storage/transfer room has been disabled and no longer controls the fan/vent on 5/11/15. The Maintenance Director and/or</p>	05/11/2015

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K 147 SS=D Bldg. 01	<p>This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation on 04/20/15 at 2:26 p.m. with the Maintenance Supervisor, the oxygen storage/transfer room was provided with a mechanically operated fan/vent but had a switch which allowed the fan to be turned off. Based on interview at the times of observation, the Maintenance Supervisor acknowledged the fan was able to be turned off.</p> <p>3.1-19(b)</p> <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>1. Based on observation and interview, the facility failed to maintain ground-fault circuit-interrupter protection for personnel in 1 of 1 Administrator bathroom. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, National Electrical Code 70, 1999 edition, Article 210-8 (b)</p>	K 147	<p>Assistant will log any identified concerns in the O2 room during routine rounds weekly and will follow up immediately to ensure compliance is maintained. The Administrator/Designee will review completed logs monthly to ensure any needed follow up has been completed.</p> <p>The rounding logs completed by the Maintenance Director and/or Assistant that will be reviewed monthly by the Administrator/Designee, will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is maintained. The QA Committee will make recommendations for needed changes and/or follow up.</p> <p>Compliance date: 5/11/15</p> <p>K 147 1. The outlet above the sink in the Administrators office bathroom has been replaced with the proper GFI outlet on 4/24/15. 2. The outlet in the Assistant Director of Nursing office bathroom has been replaced with the proper GFI outlet on 4/24/15. 3. The uncovered electrical receptacle in the Therapy office now has a cover on 4/24/15. 4. The multi plug adapter was</p>	05/12/2015

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	<p>Other than dwelling units, requires all 125-volt, single-phase, 15- and 20-ampere receptacles installed in (1) Bathrooms shall have ground-fault circuit-interrupter protection for personnel. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observation on 4/20/15 at 2:05 p.m., an outlet was discovered above a sink with no test or reset features. Based on interview at the time, the Maintenance Supervisor acknowledged at the time of observation, the outlet should have ground-fault circuit-interrupter protection.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain ground-fault circuit-interrupter protection for personnel in 1 of 1 Assistant Director of Nursing office. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, National Electrical Code 70, 1999 edition, Article 210-8 (b) Other than dwelling units, requires all 125-volt, single-phase, 15- and 20-ampere receptacles installed in (1) Bathrooms</p>		<p>removed from room 410 on 4/24/15 5. The power strip in room 403 was removed on 5/7/15 The Maintenance Director and Assistant were in-serviced on 5/12/15 that all areas of the facility will be checked on a weekly basis to ensure that no medical equipment or electrical appliances are plugged into power strips and/or are plugged into multi plugged adapters that are plugged into power strips. Further in-servicing was conducted on uncovered electrical receptacles and proper GFI's if any outlets are found non compliant. The Maintenance Director and/or Assistant will continue to log any identified concerns regarding outlets and multi plug adapters being used improperly during routine rounds weekly and will follow up immediately to ensure compliance is maintained. The Administrator/Designee will review completed logs monthly to ensure any needed follow up has been completed. The rounding logs completed by the Maintenance Director and/or Assistant that will be reviewed monthly by the Administrator/Designee, will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is maintained. The QA Committee will make recommendations for</p>	

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	<p>shall have ground-fault circuit-interrupter protection for personnel. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observation on 4/20/15 at 11:30 a.m., an outlet was discovered above a sink with no test or reset features. Based on interview at the time of observation, the Maintenance Supervisor acknowledged at the time of observation, the outlet should have ground-fault circuit-interrupter protection.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to maintain an electrical outlet in 1 of 1 Therapy front office. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 04/20/15 at 12:27 p.m., an electric receptacle in the</p>		<p>needed changes and/or follow up. Completion date: 5/12/15</p>				

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	<p>Therapy front office was uncovered. The Maintenance Supervisor acknowledged at the time of observation, the wiring should have been protected by a face plate.</p> <p>3.1-19(b)</p> <p>4. Based on observation and interview, the facility failed to ensure 1 of 1 multiplug adapter was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. 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 two residents.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 04/20/2015 at 11:02 a.m., a multiplug adapter was located in resident room 410. Two televisions were plugged into a multiplug adapter. Based on interview at the time of observation, the mutliplug adapter was acknowledged by the Maintenance Supervisor.</p> <p>3.1-19(b)</p>			

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	<p>5. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were 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 that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 2 residents.</p> <p>Findings include:</p> <p>Based on observation the Maintenance Supervisor on 04/20/2015 at 11:00 a.m. in resident room 403, a power strip was used to power a refrigerator. Based on interview at the time of observation with the Maintenance Supervisor, he acknowledged the power strip deficiency.</p> <p>3.1-19(b)</p>			