

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2016
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NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410
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K 0000 Bldg. 02	<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: 01/29/16</p> <p>Facility Number: 010739 Provider Number: 155674 AIM Number: 200856890</p> <p>At this Life Safety Code survey, Spring Mill Health Campus 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 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>Spring Mill Health Campus is a two story skilled nursing facility of Type II (111) construction built in 2007 that is attached to a two story assisted living building of Type V (111) construction that was built in 1998. The skilled nursing facility is separated from the assisted living building by a 2-hour rated fire wall. The skilled nursing building is fully</p>	K 0000	<p>The preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Life Safety Code Recertification and State Licensure Survey on January 29, 2016. Please accept this Plan of Correction as Spring Mill Healthcare credible allegation of compliance effective February 28, 2016 Spring Mill respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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K 0038 SS=E Bldg. 02	<p>sprinklered and has supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The facility has a capacity of 53 and had a census of 46 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review on 02/03/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1 Based on observation, record review, and interview, the facility failed to ensure 1 of 1 courtyard exits without a clinical diagnosis were allowed access to locked exit doors. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily</p>	K 0038	<p>K038</p> <ol style="list-style-type: none"> Courtyard exit door was immediately labeled with the code. All staff and residents have the potential to be affected. No other courtyards noted. Plant Operations were in-serviced to ensure courtyard exit doors are labeled with codes. Director of Plant Operations will audit the courtyard exit door monthly to ensure the exit door is labeled with the code and report findings monthly to QAA. 	02/28/2016

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K 0046 SS=E Bldg. 02	<p>unlock such doors at all times. This deficient practice could affect up to 11 residents.</p> <p>Findings include: Based on observation with the Director of Plant Operations and the Executive Director on 01/29/16 at 11:14 a.m., the courtyard exit door was held in the locked position with a magnetic hold down device. Furthermore, the exit door was equipped with an electronic keypad entry system that allowed staff to open the locked exit doors with a combination. A code was not posted at the exit door. Based on interview at the time of observation, the Director of Plant Operations and the Executive Director acknowledged the aforementioned condition. 3.1-19(b)</p> <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 observation and interview; the facility failed to ensure 1 of 2 battery operated emergency lights near resident room 2211 in the facility was maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to</p>	K 0046	<p>4. QAA will monitor for any trends and make recommended corrections to the plan of correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained.</p> <p>5. Correction of K038 will be completed by 2/28/2016</p> <p>K046</p> <p>1. Battery operated emergency light near resident room 2211 was repaired.</p> <p>2. All staff and residents on the 2000 hall have the potential to be</p>	02/28/2016

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K 0048 SS=C Bldg. 02	<p>be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. 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. This deficient practice could affect staff and up to 13 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations and the Executive Director on 01/29/16 at 12:14 p.m., the battery operated emergency light near resident room 2211 failed to illuminate when the test button was pressed. Based on interview at the time of observation, the Director of Plant Operations and the Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1</p>		<p>affected by this. Director of Plant operations inspected All other battery operated emergency lights on the 2000 hall. Any deficiencies noted were corrected at that time.</p> <p>3.. Plant Operations was in-serviced on the importance of ensuring emergency lighting is in good operational status. Director of Plant Operations or Designee will audit 5 battery operated emergency lights weekly to ensure good operational status and report findings monthly to QAA.</p> <p>4. QAA will monitor for any trends and make recommended corrections to the plan of correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained.</p> <p>5. Correction of K046 will be completed by 2/28/2016</p>	

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	<p>Based on record review and interview, the facility failed to provide a written plan that included the evacuation of smoke compartments in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a record review with the Director of Plant Operations and the Executive Director on 01/29/16 at 1:05 p.m., the "Fire" plan indicated that the health care portion of the building contained 2 smoke compartments. Based on observation, the Director of Plant Operations confirmed that the four sets of doors that were discovered were fire barriers. Based on interview at the time of observation, the Director of Plant</p>	K 0048	<p>K048</p> <ol style="list-style-type: none"> 1. Fire Plan was updated to include 4 smoke compartments 2. All staff and residents have the potential to be affect. Facility Fire plan books updated to reflect the changes made. 3. Director of Plant Operations or designee will in-service employees of the corrections made to the Facility Fire Plan and audit 5 employees monthly to ensure proper knowledge of the number of smoke compartments located in the facility and report findings monthly to QAA. 4. QAA will monitor for any trends and make recommended corrections to the plan of correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained. 5. Correction of K048 will be completed by 2/28/2016 	02/28/2016			

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K 0050 SS=C Bldg. 02	<p>Operations and the Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 3 of 4 quarters. This deficient practice affects all staff and residents.</p> <p>Findings include:</p> <p>Based on record review of the fire drills forms with the Director of Plant Operations on 01/29/16 at 10:41 a.m., three sequential first shift fire drills took place between 11:04 a.m. and 12:07 p.m. for three of the last four quarters. Based on interview at the time of record review,</p>	K 0050	<p>K050</p> <ol style="list-style-type: none"> 1. A new Fire Drill schedule for 2016 was implemented prior to the Life Safety Audit and noted to be in compliance by surveyor. 2. All staff and residents have the potential to be affected. 2016 schedule was noted to have been corrected & implemented 3. Director of Plant Operation was in-serviced on the importance of rotating fire drills between shifts. Director of Plant Operations or designee will audit Fire Drill rotation 	02/28/2016

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K 0051 SS=E Bldg. 02	<p>the Director of Plant Operations acknowledged the aforementioned condition.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 Based on observation and interview, the facility failed to ensure 1 of 1 smoke</p>	K 0051	<p>monthly to ensure rotation is completed between all shifts and report findings to monthly to QAA.</p> <p>4. QAA will monitor for any trends and make recommended corrections to the plan of correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained. 5. Correction of K050 will be completed by 2/28/2016</p>	02/28/2016

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K 0052 SS=C Bldg. 02	<p>detector in the corridor outside resident room 2103 was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect staff and at least 12 residents.</p> <p>Findings include: Based on observation with the Director of Plant Operations and the Executive Director on 01/29/16 at 11:35 a.m., the corridor outside resident room 2103 had a smoke detector located twelve inches away from an HVAC vents. Based on interview at the time of observation, the Director of Plant Operations and the Executive Director acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance</p>				<ol style="list-style-type: none"> The smoke detector in the corridor outside of room 2103 has been corrected to ensure air flow would not adversely affect operation . All staff & residents of the 2000 hall have the potential to be affected. Director of Plant Operations conducted a visual audit of the 2000 hall. Any deficiencies found were corrected at that time. Director of Plant Operations or designee will report findings to QAA monthly QAA will monitor for any trends and make recommended corrections to the plan of correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained. Correction of K038 will be completed by 2/28/2016 		

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	<p>and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7,</p> <p>Based on record review and interview, the facility failed to ensure 32 of 32 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 0052	<p>K052</p> <ol style="list-style-type: none"> 1. Facility Sensitivity test of smoke detectors was completed by Koorsen on 2/2/2016. 2. All staff and residents have the potential to be affected. Any deficiencies were corrected at that time. 3. Plant Operations Director to ensure Sensitivity test of smoke detectors are scheduled per the recommended guidelines and report findings to QAA 4. QAA will monitor for any trends and make recommended corrections to the plan of correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained. 5. Correction of K052 will be completed by 2/28/2016 	02/28/2016

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K 0056 SS=D Bldg. 02	<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 staff, resident, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Director of Plant Operations and the Executive Director on 01/29/16 at 1:27 p.m., no sensitivity documentation was available for review. Based on an interview at the time of record review, the Director of Plant Operations and the Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system installed in accordance with NFPA13,</p>			

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	<p>Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1.</p> <p>Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 sprinkler head in Social Service office was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Table 5-6.5.1.2 states that distance between a sprinkler head an obstruction less than 1 foot away cannot be lower than the sprinkler head deflector. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations and the Executive Director on 01/29/16 at 12:27 p.m., the spray pattern for the sprinkler head in the</p>	K 0056	<p>K056</p> <ol style="list-style-type: none"> 1. Sprinkler head near the Social Worker office spray pattern was corrected from obstruction. 2. All Staff and Residents on the 2000 hall have the potential to be affected. Plant Operations Director visually inspected all other sprinkler heads to ensure spray patterns were free of obstruction. Any deficiencies were corrected at that time. 3. Director of Plant Operations or designee will report findings to QAA 4. QAA will monitor for any trends and make recommended corrections to the plan of correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained. 5. Correction of K056 will be completed by 2/28/2016 	02/28/2016

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K 0062 SS=E Bldg. 02	<p>Social Service office was located next to a ceiling light. Measurements showed the sprinkler head was 6.75 inches away from the ceiling light. The ceiling light was measured to be 1.5 inches lower than the sprinkler head deflector. Based on interview at the time of observation, the Director of Plant Operations and the Executive Director acknowledged the abovementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 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 5 of 8 corroded sprinkler heads in the Health Care #1 Entrance Overhang. LSC 33.2.3.5.2 refers to LSC section 9.7. 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</p>	K 0062	<p>K062</p> <p>1. Facility signed a work order to replace 5 of 8 corroded sprinkler heads in the Health Care 1 or 1000 hall Entrance Overhang.</p> <p>2. All Staff and Residents on the 1000 hall have the potential to be affected. Director of Plant Operations visually inspected all sprinkler heads in the Health Care 1 or 1000 hall Entrance Overhang. A work order was signed to replace 8 of 8 sprinkler heads in the Health Center 1 or 1000 hall Entrance</p>	02/28/2016			

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NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0064 SS=E Bldg. 02	<p>practice could affect staff and at least 10 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations and the Executive Director on 01/29/16 at 11:42 a.m., five sprinkler heads were corroded under the overhang outside the Health Care #1 Entrance. Based on interview at the time of observation, the Director of Plant Operations and the Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguishers in Health Care #1 corridor was readily accessible at all times. NFPA 10, Standard for Portable Fire Extinguishers, Section 1-6.3 requires that fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. This deficient practice could affect staff and up to 10 residents.</p>	K 0064	<p>Overhang.</p> <p>3. Director of Plant Operations or designee will visually audit sprinkler heads on the Health Center Entrance Overhang monthly for corrosion and report findings monthly to QAA</p> <p>4. QAA will monitor for any trends and make recommended corrections to the plan of correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained.</p> <p>5. Correction of K062 will be completed by 2/28/2016</p> <p>K064</p> <p>1. The front glass cover on 1 of 1 fire extinguishers in the Health Care 1 corridor was removed to ensure accessibility.</p> <p>2. All Staff and up to 10 residents on the Health Center 1 or 1000 hall have the potential to be affected. Director of Plant Operations visually inspected all other fire extinguishers</p>	02/28/2016

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NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
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K 0076 SS=D Bldg. 02	<p>Findings include:</p> <p>Based on observation with the Director of Plant Operations and the Executive Director on 01/29/16 at 11:27 a.m., the fire extinguishers in the corridor near resident room 1106 was in locked wall mounted cabinet. Based on interview at the time of observation, the Director of Plant Operations did not have a key. When asked if staff have a key, the Director of Plant Operations confirmed not all staff have keys.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 cylinders in Health Care #1 Medication Room of</p>	K 0076	<p>on Health Care 1 or 1000 hall. Any deficiencies were corrected at that time.</p> <p>3. Director of Plant Operations or designee is to perform a monthly audit of all fire extinguishers to ensure accessibility and report findings monthly to QAA.</p> <p>4. QAA will monitor for any trends and make recommended corrections to the plan of correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained.</p> <p>5. Correction of K064 will be completed by 2/28/2016</p> <p>K076</p> <p>1. The Oxygen cylinder that was</p>	02/28/2016			

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K 0130 SS=F Bldg. 02	<p>nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations and the Executive Director on 1/29/16 at 11:40 a.m., Heath Care #1 Medication Room had one oxygen cylinder that was freestanding on the floor. Based on interview at the time of observation, the Director of Plant Operations and the Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS Miscellaneous</p> <p>List in the REMARKS sections, any items</p>		<p>freestanding on the floor of the Health Care 1 or 1000 hall medication room was removed.</p> <p>2. All staff on Health Care 1 or 1000 hall have the potential to be affected. Director of Plant Operations or designee visually inspected all other medication rooms to ensure proper storing of oxygen cylinders.. Any deficiencies noted were corrected at that time.</p> <p>3. Director of Plant Operations or designee is to in-service nursing employees on proper storage of oxygen cylinders. Director of Plant Operations or designee is to audit 5 nursing employees weekly in regards to proper storing of oxygen cylinders and report findings monthly to QAA.</p> <p>4. QAA will monitor for any trends and make recommended corrections to the plan of correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained.</p> <p>5. Correction of K076 will be completed by 2/28/2016</p>	

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	<p>that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.THER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 2 of 3 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>	K 0130	<p>K130</p> <p>1. A) The two separate three eights inch door penetrations in the 1st floor Health Care fire barrier were sealed with a fire barrier sealant (CP25WBT INTUMESCENT)</p> <p>B) The two by three inch unsealed penetration in the Health Care/Office fire barrier and one inch gap around the conduit was sealed with a fire barrier sealant (CP25WBT INTUMESCENT)</p> <p>C) The one inch unsealed penetration gap around cable in the Health Care 1 Service Corridor was sealed with a fire barrier sealant (CP25WBT INTUMESCENT)</p> <p>D) The 5 sealed penetrations on the 2nd floor of Health Care/Assisted Living fire barrier was that were sealed with a pink substance were resealed with a fire barrier sealant (CP25WBT INTUMESCENT)</p> <p>E) The one pink sealed penetration in the 2nd floor Health Care fire barrier was resealed with fire barrier sealant (CP25WBT</p>	02/28/2016

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	<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. This deficient practice could affect all residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Plant Operations and the Executive Director on 01/29/16 between 11:21 a.m. and 12:44 p.m., the following fire wall penetrations were discovered:</p> <p>a) two separate three eighths inch door penetrations in the 1st floor Health Care fire barrier</p> <p>b) a two by three inch unsealed penetration in the Health Care/Office fire barrier. Additionally, another one inch unsealed penetration gap around conduit.</p> <p>c) a one inch unsealed penetration gap around cable in the Health Care #1 Service Corridor fire barrier.</p> <p>d) 5 sealed penetrations in the 2nd floor Health Care/Assisted Living fire barrier was sealed by a pink putty. No documentation was available for review for the pink putty.</p> <p>e) One pink sealed penetration in the 2nd floor Health Care fire barrier was sealed by a pink putty. No documentation was</p>		<p>INTUMESCENT)</p> <p>2) All staff and resident s on health center had the potential to be affected. Director of Plant Operations and designee visually conducted an audit to ensure no further penetrations were noted to the fire barrier or doors on Health Care 1 and Health Care 2</p> <p>3. Director of Plant Operations will report findings to QAA</p> <p>4. QAA will monitor for any trends and make recommended corrections to the plan of correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained.</p> <p>5. Correction of K130 will be completed by 2/28/2016</p>	

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K 0144 SS=C Bldg. 02	<p>available for review for the pink putty. Based on interview at the time of each observation, the Director of Plant Operations and the Executive Director acknowledged each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 3-6.4.1.1 Maintenance and Testing Transfer Switches states the general shall be maintained as to be capable of supplying service with the shortest time practical and within 10 seconds. This deficient practice could affect all staff, residents, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Director of Plant Operations on 01/29/16 at 10:25 a.m., the monthly testing forms failed to include the transfer time for twelve</p>	K 0144	<p>K144</p> <p>1) The transfer time and 5 minute cool down time was added to the generator inspection audit.</p> <p>2) All residents as well as staff and visitors had the potential to be affected. Director of Plant Services</p> <p>3) Director of Plant Operations will audit the transfer time and 5 minute cool down period monthly and report findings to QAA</p> <p>4. QAA will monitor for any trends and make recommended corrections to the plan of correction as needed. QAA will monitor for 90 days or until</p>	02/28/2016

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	<p>months of the last twelve months of testing. Based on interview at the time of record review, the Director of Plant Operations acknowledged the aforementioned condition.</p> <p>3-1.19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shut down. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Generator monthly testing log</p>		<p>100% compliance is obtained.</p> <p>5. Correction of K144 will be completed by 2/28/2016</p>	

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K 0147 SS=D Bldg. 02	<p>with the Director of Plant Operations on 01/29/16 at 10:25 a.m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Director of Plant Operations acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 multiplug and 2 of 2 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 staff and up to 2</p>	K 0147	<p>K147</p> <p>1) The second surge protector powering another surge protector which powered the phone components was removed along with the multiplug powering a oxygen concentrator.</p> <p>2) Staff and up to two resident that the potential to be affected. Director of Plant Operations visually conducted a audit of the resident</p>	02/28/2016

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K 0160 SS=F Bldg. 02	<p>residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations and the Executive Director on 01/29/16 at 11:25 a.m. then again at 12:03 p.m., a surge protector was powering another surge protector powering phone components in the Mechanical Phone Room. Then again a multiplug was powering an oxygen concentrator in resident room 2218. Based on interview at the time of each observation, the Director of Plant Operations and the Executive Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record.</p> <p>New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Fire Fighter's Service Requirements. 9.4.2, 9.4.3, 18.5.3 (Includes firefighters service phase I key recall and smoke detector automatic recall, firefighters service phase II emergency</p>		<p>rooms. All deficiencies noted were corrected at that time.</p> <p>3) Director of Plant Operations or designee will in-service employees on surge protectors and multiplug connectors. Director of Plant Operations or designee will audit 5 resident rooms weekly and report findings to QAA.</p> <p>4. QAA will monitor for any trends and make recommended corrections to the plan of correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained.</p> <p>5. Correction of K147 will be completed by 2/28/2016</p>	

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	<p>in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)</p> <p>Based on observation and interview; the facility failed to ensure 1 of 1 elevator equipment rooms was provided with an electrical shunt trip when provided with sprinkler coverage. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice would affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations and the Executive Director on 1/29/16 at 11:33 a.m., the elevator equipment room contained 1 sprinkler head. Based on interview at the time of observation, the Director of Plant Operations and the Executive Director was unable to confirm the elevator equipment was provided with an elevator shunt trip.</p>	K 0160	<p>K160</p> <p>1) Upon further evaluation Evorik Electric was able to note that the shunt trip for elevator 1 of 1 was located in the electrical room. Evorik Electric labeled the electrical panel & elevator room.</p> <p>2) All Staff were potentially affected. All deficiencies noted were corrected at that time.</p> <p>3) Director of Plant Operations to report findings to QAA</p> <p>4. QAA will monitor for any trends and make recommended corrections to the plan of correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained.</p> <p>5. Correction of K160 will be completed by 2/28/2016</p>	02/28/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

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