

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2014
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NAME OF PROVIDER OR SUPPLIER CLOVERLEAF OF KNIGHTSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/22/14</p> <p>Facility Number: 000296 Provider Number: 155542 AIM Number: 100467820</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Cloverleaf of Knightsville 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), and 410 IAC 16.2. The original facility and two additions constructed prior to March 1, 2003 were surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility with a partial basement was surveyed as two separate buildings due to the construction dates of the facility. The original facility and two additions constructed prior to March 1,</p>	K010000	<p>This plan of correction is submitted as required by law. By submitting this plan of correction Cloverleaf Healthcare does not admit that the citations listed on the CMS 2567 exist nor does it admit to any statement, finding, facts or conclusion that forms the basis of alleged citations.</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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K010025 SS=D	<p>2003 were determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors, in spaces open to the corridors and in resident rooms on A wing. B and C Wing resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 102 and had a census of 90 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The detached laundry is unsprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/27/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p>						

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	<p>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 smoke partitions such as ceilings were sealed to limit the transfer of smoke. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke. This deficient practice could affect visitors, staff and any resident accessing the medical records smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/22/14 at 1:10 p.m., a 15 foot by 15 foot storage room was located across the hall from the maintenance director's office. A laid in ceiling was missing six tiles exposing the damaged plaster ceiling above. A 30 by 30 inch section of the plaster was missing exposing openings between the supporting slats into the attic above. The maintenance director agreed at the time of observation, the ceiling could not prevent the transfer of smoke in the event of fire.</p> <p>3.1-19(b)</p>	K010025	<p>K025 Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue 1.) This six tiles missing exposing the damaged plaster was properly maintained and tiles replaced2.) There were no other tiles missing throughout the facility exposing plaster in the ceiling.3.) Maintenance Director walked through facility and audited ceiling for deficient practice.4.) Maintenance Director will conduct monthly walk through audits to look for and issues regarding this deficient practice and administrator will monitor.6-21-14</p>	06/21/2014

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K010029 SS=D	<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 provide automatic door closers on 2 of 10 doors providing access to hazardous areas. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice could affect staff, visitors and any resident accessing the medical records office</p>	K010029	<p>K029</p> <p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue</p> <p>1.) The doors for Storage Room 8 and the Maintenance office has been maintained with a self closure and will fully latch when closed.</p> <p>2.) All doors were checkd in building to assure proper closure</p> <p>3.)Maintenance Director will continue to monitor and audit all doors on a quarterly basis.</p>	06/21/2014

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	<p>smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/22/14 between 12:30 p.m. and 12:45 p.m., the maintenance office was cluttered with equipment and materials for, and in need of, repair. The door had no self closer and was damaged in such a way the door had to be pushed open because it dragged on the floor. The maintenance director said at the time of observation, the door needed repair. In addition, a 15 by 15 foot storage room across from the maintenance shop was filled with combustible materials and other equipment in storage. The door providing access from the corridor had no self closer and the door did not latch when the door was closed. The maintenance director acknowledged at the time of observations, these doors were not self closing and the storage room door latch was not working.</p> <p>3.1-19(b)</p>		4.)Administrator will monitor for compliance.		

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K010038 SS=E	<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 Based on observation and interview, the facility failed to ensure exit discharge for 1 of 11 emergency exits was arranged to be accessible. LSC 19.2.1 requires compliance with LSC 7.1, Means of Egress. LSC 7.1.3.2.3 requires an exit enclosure shall not be used for any purpose with the potential to interfere with its use as an exit. LSC 7.1.10.1 "Means of egress shall be continuously free of all obstructions or impediments to full instant use in case of fire or other emergency use." This deficient practice affects visitors, staff and 10 or more residents on the A hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/22/14 at 12:50 p.m., the emergency exit discharge from the A hall activity/dining room</p>	K010038	<p>K038 Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue 1.) Fence in court yard to be replaced. Have quote and waiting on company to complete job2.) All other emergency exits were accessible and free of all obstructions.3.) Maintenance Director walked all exits to assure all were free from obstacles in case of emergency.4.) Maintenance Director to do weekly audits of means of egress for exits during emergencies. Administrator to monitor.</p>	06/21/2014

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K010044 SS=E	<p>required passing through a six foot wooden fence gate to access the public way. The gate leaned to one side and had to be lifted to be opened. The maintenance director said at the time of observation, the bottom hinge was broken between the gate and the fence. He agreed at the time of observation, the condition of the gate would interfere with access to the public way in the event of an emergency.</p> <p>3.1-(19)</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 facility failed to ensure 1 of 3 fire door sets was arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This</p>	K010044	<p>K044</p> <p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue</p> <p>Maintenance Director has maintained and tested a wing fire door to assure that when doors were released this door latched.</p> <p>Maintenance Director has checked all other fire doors to assure that the latching</p>	06/21/2014

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K010051 SS=F	<p>deficient practice affects visitors, staff and 10 or more residents on A wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/22/14 at 11:45 a.m., the fire door set near the A wing nurses' station was tested twice manually with the maintenance director. One door in the fire door set failed to latch each time the doors were released to close. The door failed to latch again at 2:10 p.m. when the fire alarm was activated. The maintenance director agreed at the time of observations, something interfered with the door latching.</p> <p>3.1-19(b)</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</p>		<p>mechanism worked effectively.</p> <p>Maintenance Director will do weekly rounds for 3 months and then monthly thereafter.</p> <p>Administrator to monitor</p>		

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	<p>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 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 maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/22/14 at 2:10 p.m., the maintenance director identified a circuit breaker box he said was connected to the emergency generator power and contained the fire alarm</p>	K010051	K051Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue The emergency power breaker box was properly labeled identifying the Fire Alarm Circuit control.Maintenance director to monitor the breaker box quarterly to assure red label identifying Fire Alarm Circuit Control is properly done.Administrator to monitor	06/21/2014

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K010056 SS=D	control panel (FACP) breaker. The emergency power breaker box lacked identification and the FACP circuit breaker was not identified. The maintenance supervisor stated at the time of observation, he would have to find out which circuit connected to the FACP. 3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully			
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	<p>supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to insure 1 of 7 smoke compartments had sprinkler heads installed in accordance with NFPA 13, Section 5-1.1 and 5-6.3.4 which requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect any of the visitors, staff, and any resident accessing the administrative wing where the dietary office was located.</p> <p>Findings include:</p> <p>Based on an observation on 05/22/14 at 12:45 p.m. with the maintenance director, the dietary office had two pendant sprinkler heads located three and a half feet from one another. The maintenance director confirmed at the time of observation, the separation of the sprinkler heads was less than six feet.</p> <p>3.1-19(b)</p>	K010056	<p>K056 Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue 1.) Safe care came and removed sprinkler head from area that was placed inappropriately. 2.) Toured building to determine any other deficient areas3.) No other sprinkler heads were determined to be closer than 6 ft together4.) Maintenance will continue to watch and assure that no heads were missed quarterly and if new heads are installed to assure location is acceptable. Administrator to monitor</p>	06/21/2014	

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K010062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 6 sprinkler heads protecting the A hall lounge was maintained. This deficient practice could affect all staff, visitors and 6 or more residents in the A hall lounge.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/22/14 at 11:40 a.m., a sprinkler head escutcheon was displaced three fourths inch below the A hall lounge ceiling leaving a gap into the attic space above. The maintenance director acknowledged at the time of observation, the sprinkler escutcheon allowed an opening into the attic above.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure sprinkler heads in 2 of 7 smoke compartments were free of foreign materials. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This</p>	K010062	<p>K062Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue1.) Safe care came and replaced Sprinkler heads in c wing shower room that were coated with foreign matter or were dirty. The shower curtain was lowered therefore the sprinkler head would be able to spray patterns.2.) All sprinkler heads were assessed3.) Sprinkler heads needing replaced were.4.) Maintenance director to monitor quarterly and administrator to monitor.</p>	06/21/2014

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	<p>deficient practice affects staff, visitors and any resident accessing the administrative area which included medical records and the dietary services office.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/22/14 between 12:45 p.m. and 2:15 p.m., four sprinkler heads in the dietary office were splattered with paint, the sprinkler head protecting the maintenance office and four sprinkler heads in the general storage room near the maintenance office were coated with a thick fuzzy grime. The maintenance director agreed at the time of observations, the foreign materials could affect the function of the sprinkler heads.</p> <p>3.1-19(b)</p>			

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K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen supply storage rooms was separated by construction with a one hour fire rating. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.2. NFPA 99, 4-3.1.1.2(a)2 requires at least one hour fire resistant enclosures shall be provided for the storage of oxidizing agents such as oxygen. This deficient practice affects visitors, staff and 10 or more residents on A wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/22/14 at 12:00 p.m., six large liquid oxygen containers and eight e-cylinders were stored in the oxygen storage supply room. A penetration of the ceiling identified at the time of observation by the maintenance man as an air conditioning</p>	K010076	<p>K076Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue 1.) The ceiling in the oxygen room where the air conditioner line is coming in was filled appropriately.2.) This is the only oxygen room within the facility. 3.) Maintenance Director or his designee will audit oxygen room monthly to assure that oxygen room is seperated by a 1 hour fire rating at all times. 4.)Administrator and Maintenance Director to monitor</p>	06/21/2014			

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K010130 SS=E	<p>line was unsealed leaving a one inch gap into the attic space above. The maintenance director acknowledged at the time of observation, the unsealed gap compromised the one hour fire resistance of the enclosure.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 22 of 22 resident sleeping rooms on the A and B wings. 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 visitors, staff and 10 or more residents on the A and B wings.</p> <p>Findings include:</p> <p>Based on review of preventive maintenance documentation with the maintenance director and administrator on 05/22/14 at 3:00 p.m., an itemized listing of monthly battery operated smoke</p>	K010130	<p>K130Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue1.) An itemized listing of battery operated smoke detectors was created and audits began for preventative maintenance.2.) All residents in these areas have been safe due to batteires being changed as recommended3.) All battery operated smoke detectors were checked and are operating properly.4.) Maintenance will audit battery operated smoke detectors monthly and change batteries as needed and yearly. Administrator to monitor</p>	06/21/2014

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K010147 SS=E	<p>detector testing for each resident sleeping room on A and B halls was not available for review. The maintenance director said at the time of record review, no testing was done to be recorded.</p> <p>3.1-19(a)</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>Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring on the second and third floors of the Mitchell building. 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 could affect visitors, staff, and 10 or more</p>	K010147	<p>K147Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue1.) Refrigerator was removed off of the power strip extension cord in the Director of Nursing office2.) Maintenance director educated staff about use of power strips in the facility.3.) Maintenance director to monitor and audit building weekly to determine if appropriate items are plugged into power strips4.) Administrator to monitor</p>	06/21/2014

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K040000	<p>residents on the B hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/22/14 between 1:15 p.m. and 2:20 p.m., a power strip extension cord was used to supply power to a coffee pot, toaster and refrigerator in the medical records office and an oxygen concentrator in resident room 15. The maintenance director said at the time of observations, he was unaware of the restrictions for using power strips.</p> <p>3.1-19(b)</p> <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: 05/22/14</p>	K040000	This plan of correction is submitted as required by law. By submitting this plan of correction Cloverleaf Healthcare does not admit that the citations listed on the CMS 2567 exist nor does it admit to any statement, finding, facts or conclusion that forms the basis of				

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	<p>Facility Number: 000296 Provider Number: 155542 AIM Number: 100467820</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Cloverleaf of Knightsville 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) and 410 IAC 16.2. The 2006 addition was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>The 2006 one story addition was determined to be of Type V (111) construction and fully sprinklered. The 2006 addition has a fire alarm system smoke detection in the corridors, in spaces open to the corridors and hard wired smoke detectors in resident rooms (C Wing). The facility has a capacity of 102 and had a census of 90 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The detached laundry is unsprinklered.</p>		alleged citations.				

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K040051 SS=F	<p>The facility was found not in compliance with the aforementioned requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, 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 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, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all occupants.</p>	K040051	<p>K051Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue The emergency power breaker box was properly labeled identifying the Fire Alarm Circuit control.Maintenance director to monitor the breaker box quarterly to assure red label identifying Fire Alarm Circuit Control is properly done.Administrator to monitor</p>	06/21/2014

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K040062 SS=E	<p>Findings include:</p> <p>Based on observation with the maintenance director on 05/22/14 at 2:10 p.m., the maintenance director identified a circuit breaker box he said was connected to the emergency generator power and contained the fire alarm control panel (FACP) circuit breaker. The emergency power breaker box lacked identification and the FACP circuit breaker was not identified. The maintenance supervisor stated at the time of observation, he would have to find out which circuit connected to the FACP.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 3 sprinkler heads protecting the C wing shower were free of foreign materials such as grime. NFPA 25, 2-2.1.1</p>	K040062	K062Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue1.) Safe care came and replaced Sprinkler heads in c wing shower room that were	06/21/2014			

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	<p>requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 10 or more residents on the C wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/22/14 at 12:10 p.m., two sprinkler heads in the C wing shower were covered with a gray fuzzy grime. The maintenance director acknowledged at the time of observation, the foreign materials could affect the function of the sprinkler heads.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 3 C wing shower room sprinkler heads were free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice could affect staff and 3 residents in the C wing shower room.</p> <p>Findings include:</p>		<p>coated with foreign matter or were dirty. The shower curtain was lowered therefore the sprinkler head would be able to spray patterns.2.) All sprinkler heads were assessed3.) Sprinkler heads needing replaced were.4.) Maintenance director to monitor quarterly and administrator to monitor.</p>	

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K040147 SS=E	<p>Based on observation with the maintenance director on 05/22/14 at 12:10 p.m., the shower curtains in the C wing shower room hung two inches from the ceiling opening into the three showers. The maintenance director acknowledged at the time of observation, the curtains obstructed the spray patterns for the two sprinkler heads providing protection into these shower stalls.</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 Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords were not used as a substitute for fixed wiring. NFPA 70 National</p>	K040147	K147Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue1.) Refrigerator was	06/21/2014

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	<p>Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect visitors, staff, and 10 or more residents on C wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/22/14 between 11:50 a.m. and 12:40 p.m., power strip extension cords were used to supply power to a refrigerator and microwave in the physical therapy office, a refrigerator in resident room 64, and a refrigerator in the DON's office. The maintenance director said he was unaware of the restrictions for power strip usage.</p> <p>3.1-19(b)</p>		<p>removed off of the power strip extension cord in the Director of Nursing office2.) Maintenance director educated staff about use of power strips in the facility.3.) Maintenance director to monitor and audit building weekly to determine if appropriate items are plugged into power strips4.) Administrator to monitor</p>	