

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2015
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NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/25/15</p> <p>Facility Number: 000059 Provider Number: 155697 AIM Number: 100266560</p> <p>At this Life Safety Code survey, Clark Rehabilitation and Skilled Nursing 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and in spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a</p>	K 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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K 0018 SS=E Bldg. 01	<p>capacity of 83 and had a census of 73 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except for a mini barn and two storage pods.</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. 1) Based on observation and interview, the facility failed to ensure 1 of 100 corridor doors was capable of positive latching. This deficient practice could affect at least 10 residents using the nearby dining room as well as staff or visitors.</p> <p>Findings include:</p>	K 0018	<p>K018 1-No facility occupants were harmed and residents did not have a negative outcome related to the alleged deficient practice. Employee Break Room door adjusted so that it latches into the frame. Admissions office wedge removed from under the door and discarded. 2- All facility occupants have the potential to be affected by the alleged deficient practice. Admissions</p>	07/25/2015

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K 0027	<p>Based on observation on 06/25/15 at 11:45 a.m. with the Maintenance Director, the employee break room did not latch into the frame. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned door did not latch into the frame.</p> <p>3.1-19(b)</p> <p>2) Based on observation and interview, the facility failed to ensure doors protecting 1 of 100 corridor openings did not have an impediment to the closing of the doors. This deficient practice could affect at least 10 residents using the nearby lobby as well as staff or visitors.</p> <p>Findings include:</p> <p>Based on observation on 06/25/15 at 1:05 p.m. with the Maintenance Director, the Admissions office corridor door was held open by a wedge under the door. Based on interview during the time of observation, the Maintenance Director acknowledged the aforementioned door was blocked open and removed the wedge.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		<p>Director in-serviced by ED on 7/6/15 on policy. Employee Break Room door adjusted so that it latches into the frame. Admissions office wedge removed from under the door and discarded. 3-Employee Break Room door adjusted so that it latches into the frame. Admissions office wedge removed from under the door and discarded. Admissions Director in-serviced by ED on 7/6/15 on policy. An audit of all facility doors has been conducted and no other wedges or non latching doors were found. All corridor doors audited and all other corridor doors have automatically positive latching devices. 4-Maintenance Director or designee will conduct Preventative Maintenance Program routine rounds. Areas noted to have wedges hold open devices or corridor doors that do not have automatically positive latching devices will be removed/ fixed. All findings will be included in the facility's Continuous Quality Improvement program and the plan of action adjusted accordingly when 100% compliance is not achieved. Attachment A, B, C July 25, 2015</p>				

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SS=E Bldg. 01	<p>LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect at least 10 residents as well as staff and visitors on both sides of the 20 Hall set of smoke barrier doors.</p> <p>Findings include:</p> <p>Based on observation on 06/25/15 at 12:45 p.m. with the Maintenance Director, the coordinating device on the 20 Hall set of smoke barrier doors did not operate properly preventing the doors from closing completely leaving a three inch gap. Based on interview during the</p>	K 0027	<p>K027</p> <p>1-No facility occupants were harmed and residents did not have a negative outcome related to the alleged deficient practice. Door noted in the survey (20 hall set of smoke barrier doors) that was not functioning properly, has been fixed by adding and/or adjusting coordinators.</p> <p>2- All facility occupants have the potential to be affected by the alleged deficient practice. Door noted in the survey (20 hall set of smoke barrier doors) that was not functioning properly, has been fixed by adding and/or adjusting coordinators.</p> <p>3-Door noted in the survey (20 hall set of smoke barrier doors) that was not functioning properly, has been fixed by adding and/or adjusting coordinators.</p> <p>All cross-corridor smoke barrier doors have been audited to ensure all function properly.</p> <p>4-Maintenance Director or designee will conduct Preventative Maintenance Program routine</p>	07/25/2015

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K 0029 SS=E Bldg. 01	<p>time of observations, the Maintenance Director acknowledged the coordinator needed adjustment in order to work properly.</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 Based on observation and interview, the facility failed to ensure the doors to 3 of 10 hazardous areas automatically closed and latched into their door frames. Hazardous areas include soiled linen/trash collection rooms and rooms exceeding 50 square feet used for the storage of combustible materials. Doors to hazardous areas are required to automatically latch in the door frame</p>	K 0029	<p>rounds. Cross-corridor smoke barrier doors found to be malfunctioning will be immediately adjusted for proper functioning. All findings will be included in the facility's Continuous Quality Improvement program and the plan of action adjusted accordingly when 100% compliance is not achieved. Attachments B, C July 25, 2015</p> <p>K029 1-No facility occupants were harmed and residents did not have a negative outcome related to the alleged deficient practice. A door self-closing device has been installed on the Medical Records office door. A door latching device has been installed on the small shower room door. The self-closing device on the</p>	07/25/2015

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	<p>when closed to keep the door tightly closed. This deficient practice affects at least 20 residents and staff throughout the facility.</p> <p>Findings include:</p> <p>Based on observation on 06/25/15 with the Maintenance Director during the tour from 10:30 a.m. to 1:15 p.m., the following was noted:</p> <p>a) The medical records office lacked a door closer. The medical records office exceeded 50 square feet and was used for the storage of combustible materials such as 10 cardboard boxes filled with resident medical records. Based on interview at the time of observation, the Maintenance Director acknowledged the medical records office was used for storage of combustible materials and the door lacked a self-closing device.</p> <p>b) The small shower room was provided with a door closer but not a door latching device. The shower room had two 32 gallon size containers with one full of soiled linen stored in the shower room. Based on interview at the time of observation, the Maintenance Director acknowledged the shower room was used for storage of soiled linen/trash and the shower room door lacked a latching device.</p> <p>c) The central supply room door was</p>		<p>Central Supplydoor has been adjusted so that it latches properly.</p> <p>2- All facility occupants have the potential to beaffected by the alleged deficient practice. A door self-closing device has been installedon the Medical Records office door. A door latching device has been installed on the small shower room door. The self-closing device on the Central Supplydoor has been adjusted so that it latches properly.</p> <p>3- A door self-closing device has been installed onthe Medical Records office door. A doorlatching device has been installed on the small shower room door. The self-closing device on the Central Supplydoor has been adjusted so that it latches properly. All facility self-closing devices have beenaudited to ensure all function properly.</p> <p>4- Maintenance Director or designee will conductPreventative Maintenance Program routine rounds. Self-closing devices found to be malfunctioning will be immediately adjusted for proper functioning. Allfindings will be included in the facility's Continuous Quality Improvementprogram and the plan of action adjusted accordingly when 100% compliance is notachieved.</p> <p>Attachments B, C July 25, 2015</p>	

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K 0038 SS=A Bldg. 01	<p>provided with a self-closing device but did not completely close the door in order for the door to latch into the frame. The central supply room exceeded 50 square feet and was used for the storage of combustible materials such as cardboard boxes and medical supplies. Based on interview at the time of observation, the Maintenance Director acknowledged the central supply room was used for storage of combustible materials and the self-closer on the door needed adjustment in order to close and latch properly.</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>Based on observation and interview, the facility failed to ensure 1 of 7 exit doors with a delayed egress lock was provided with the proper signage. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7,</p>	K 0038	<p>K038</p> <p>1-No facility occupants were harmed and residents did not have a negative outcome related to the alleged deficient practice. Employee Break Room exit door provided with signage pertaining to 15 second delay.</p> <p>2-All facility occupants have the potential to be affected by the alleged deficient practice. Employee Break Room exit door provided with signage pertaining to 15 second delay.</p> <p>3-Employee Break Room exit door provided with signage pertaining to 15 second delay. All</p>	07/25/2015

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	<p>and where permitted in Chapters 12 through 42, provided:</p> <p>(a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6.</p> <p>(b) The doors unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads:</p>		<p>facility exit doors audited to ensure proper signage is provided.</p> <p>4-Maintenance Director or designee will conduct Preventative Maintenance Program routine rounds. Exit doors found to have improper signagewill receive proper signage. All findings will be included in the facility's Continuous Quality Improvement program and the plan of action adjusted accordinglywhen 100% compliance is not achieved.</p> <p>Attachments B ,C July 25, 2015</p>	

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K 0050 SS=C Bldg. 01	<p>"PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS".</p> <p>This deficient practice could affect primary staff that may use the employee break room exit.</p> <p>Findings include:</p> <p>Based on observation on 06/25/15 at 11:55 a.m. with the Maintenance Director, the employee break room exit door was provided with a fifteen second delay but lacked proper signage (d). Based on interview at the time of observation, the Maintenance Director acknowledged the door was not provided with signage pertaining to the 15 second delay.</p> <p>3.1-19(b)</p> <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,</p>	K 0050	K050 1-No facility occupants were harmed and residents did	07/25/2015			

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K 0062	<p>the facility failed to conduct fire drills under varied conditions. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Reports" with the Maintenance Director at 11:00 a.m. on 06/25/15, twelve of twelve fire drills conducted on 01/30/15, 02/27/15, 03/27/15, 04/29/14, 05/30/14, 06/28/14, 07/30/14, 08/27/14, 09/30/14, 10/30/14, 11/25/14 and 12/31/14 were held near or at the end of the month. Based on interview at the time of review, the Maintenance Director acknowledged fire drills were conducted near or at the end of the month.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101</p>		<p>not have a negative outcome related to the alleged deficient practice. The facility fire drill schedule which follows the guidelines of being held at unexpected times under varying conditions at least quarterly on each shift is implemented and all fire drills YTD have followed that schedule. 2-All facility occupants have the potential to be affected by the alleged deficient practice. Maintenance Director in-serviced by ED 7/6/14 on fire drill procedure which includes holding fire drills at unexpected times under varying conditions at least quarterly on each shift. 3-Maintenance Director/Designee will follow fire drill schedule to ensure that fire drills are held at unexpected times under varying conditions at least quarterly on each shift. ED/Designee will ensure fire drills are held per regulation. Maintenance Director in-serviced by ED 7/6/14 on fire drill procedure which includes holding fire drills at unexpected times under varying conditions at least quarterly on each shift. 4-ED/Designee will conduct monthly CQI to ensure fire drill schedule is being followed for compliance. If 100% accuracy is not obtained an action plan will be developed by ED. CQI tool will be done monthly on an ongoing basis. Attachments B, C, D, E, F, G, H July 25, 2012</p>		

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SS=A Bldg. 01	<p>LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 requires sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice in the staff-only break room would not directly affect residents.</p> <p>Findings include:</p> <p>Based on observation on 06/25/15 at 11:40 a.m. with the Maintenance Director, a six foot length of section of a four inch natural gas pipe was hung onto and supported by one cable which was attached to the sprinkler pipe in the employee break room. Based on interview at the time of observation, the Maintenance Director acknowledged the sprinkler pipe in the employee break room was supporting a phone cable.</p> <p>3.1-19(b)</p>	K 0062	<p>K062</p> <p>1-No facility occupants were harmed and residents did not have a negative outcome related to the alleged deficient practice. Phone cable in Employee Break Room extricated from sprinkler pipe.</p> <p>2-All facility occupants have the potential to be affected by the alleged deficient practice. Phone cable in Employee Break Room extricated from sprinkler pipe.</p> <p>3-Phone cable in Employee Break Room extricated from sprinkler pipe. All facility sprinkler pipes audited to ensure none were being used to support nonsystem components.</p> <p>4-Maintenance Director or designee will conduct Preventative Maintenance Program routine rounds. Any sprinkler pipes found to be used as a support for nonsystem components will be immediately resolved. All findings will be included in the facility's Continuous Quality Improvement program and the plan of action adjusted accordingly when 100% compliance is not achieved.</p> <p>Attachments B, C July 25, 2015</p>	07/25/2015

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K 0064 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to inspect 2 of 14 portable fire extinguishers throughout the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect at least 5 residents using the smoke hut or beauty shop.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility on 06/25/15 the following was noted:</p>	K 0064	<p>K064 1-No facility occupants were harmed and residents did not have a negative outcome related to the alleged deficient practice. Both the smoke hut and beauty shop fire extinguishers have been inspected and have the appropriate documentation verifying they are available and will operate. 2- All facility occupants have the potential to be affected by the alleged deficient practice. Both the smoke hut and beauty shop fire extinguishers have been inspected and have the appropriate documentation verifying they are available and will operate. Maintenance Director in-serviced by ED on 7/6/15 on fire extinguisher inspection protocol. 3- Both the smoke hut and beauty shop fire extinguishers have been inspected and have the appropriate documentation verifying they are available and will operate. Maintenance Director in-serviced by ED on 7/6/15 on fire extinguisher inspection protocol. All facility fire extinguishers</p>	07/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2015
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NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129
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K 0069 SS=E Bldg. 01	<p>a) At 12:10 p.m., the monthly inspection tag on the fire extinguisher located in the smoke hut lacked documentation of a monthly inspection for the months of November and December of 2014 since the Annual Inspection which occurred in October of 2014. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>b) At 12:30 p.m., the monthly inspection tag on the fire extinguisher located in the Beauty Shop lacked documentation of a monthly inspection for the months of October, November, December, 2014 and January, February, March, April and May, 2015 since the Annual Inspection which occurred in July of 2014. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure the grease filters on 1 of 1 kitchen stove hoods was properly positioned to drain the grease</p>	K 0069	<p>audited to ensure appropriate inspection and documentation completed timely. 4- Maintenance Director or designee will conduct Preventative Maintenance Program routine rounds. Fire extinguishers found to have inappropriate inspection documentation will be inspected immediately. All findings will be included in the facility's Continuous Quality Improvement program and the plan of action adjusted accordingly when 100% compliance is not achieved. Attachments B, C, D July 25, 2015</p> <p>K069 1-No facility occupants were harmed and residents did not have a negative outcome related</p>	07/25/2015

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K 0076	<p>into the containers. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1998 Edition, at 3.2.7 says grease filters requiring a specific orientation to drain grease shall be clearly so designated, or the hood shall be constructed so filters cannot be installed in the wrong orientation. This deficient practice could affect kitchen staff and at least 10 residents in the adjacent dining room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 06/25/15 at 12:20 p.m., grease baffle filters in the kitchen stove hood were installed horizontally instead of vertically to drain grease from the exhaust hood. Based on interview at the time of observation, the Maintenance Director indicated the kitchen staff run the filters through the dishwasher monthly and acknowledged the baffle grease filters were not installed in the correct orientation.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		<p>to the alleged deficient practice. Grease baffle filters in the kitchen stovehood have been installed vertically to drain grease from the exhaust hood.</p> <p>2-All facility occupants have the potential to beaffected by the alleged deficient practice. . Grease baffle filters in the kitchen stove hood have been installedvertically to drain grease from the exhaust hood. Kitchen staff in-serviced by Maintenancestaff on 7/13/15 on appropriate grease baffle filter installation.</p> <p>3- Grease baffle filters in the kitchen stove hoodhave been installed vertically to drain grease from the exhaust hood. Kitchen staff in-serviced by Maintenancestaff on 7/13/15 on appropriate grease baffle filter installation.</p> <p>4- Maintenance Director or designee will conduct PreventativeMaintenance Program routine rounds. Grease baffle filters found to be installed incorrectly will becorrectly installed immediately. Allfindings will be included in the facility's Continuous Quality Improvementprogram and the plan of action adjusted accordingly when 100% compliance is notachieved. Attachments B, C, I July 25, 2015</p>		

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SS=E Bldg. 01	<p>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 cylinders of nonflammable gases such as helium was 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 at least 10 residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 06/25/15 at 12:15 p.m., a large helium cylinder was standing in the Activity office corner without support. The Maintenance Director acknowledged at the time of observation, the cylinder</p>	K 0076	<p>K076</p> <p>1-No facility occupants were harmed and residents did not have a negative outcome related to the alleged deficient practice. Helium cylinder in the Activity office has been properly secured.</p> <p>2-All facility occupants have the potential to be affected by the alleged deficient practice. Helium cylinder in the Activity office has been properly secured. Activity staff in-serviced by Maintenance staff on 7/6/15 on appropriate helium tank storage.</p> <p>3- Helium cylinder in the Activity office has been properly secured. Activity staff in-serviced by Maintenance staff on 7/6/15 on appropriate helium tank storage.</p> <p>4- Maintenance Director or designee will conduct Preventative Maintenance Program routine rounds. Helium tank found to be secured incorrectly will be correctly secured immediately.</p> <p>All findings will be included in the facility's Continuous Quality Improvement program and the</p>	07/25/2015

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K 0147 SS=E Bldg. 01	<p>should have been in a stand or properly secured with a chain.</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>Based on observation and interview, the facility failed to ensure 6 of 6 pieces of medical equipment and high current draw electrical devices were not plugged into powers strips or extension cords as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. 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 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 at least 20 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 06/25/15 with the Maintenance Director during the tour from 10:30 a.m. to 1:15 p.m., the following was noted:</p> <p>a) A window air conditioner was</p>	K 0147	<p>plan of action adjusted accordingly when 100% compliance is notachieved. Attachments B, C, J July 25, 2015</p> <p>K147</p> <p>1- No facility occupants were harmed and residentsdid not have a negative outcome related to the alleged deficient practice. Allitems noted in the survey to be plugged into power strips (break room airconditioner, medical records and MDS portable air conditioners, dining room icemachine, room 41 electric bed, room 31 suction machine) were unplugged frompower strips and plugged directly into electrical outlets.</p> <p>2--All facility occupants have the potential to beaffected by the alleged deficient practice. All items noted in the survey to be pluggedinto power strips (break room air conditioner, medical records and MDS portableair conditioners, dining room ice machine, room 41 electric bed, room 31suction machine) were unplugged from power strips and plugged directly intoelectrical outlets. Maintenance Directorin-serviced by ED on 7/6/15 on Life Safety Code regulation K147.</p>	07/25/2015

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	<p>plugged into a power strip in the employee break room.</p> <p>b) Portable air conditioners were plugged into power strips in the medical records office and in the MDS office. The power cords for these portable air conditioners had attached tags that specifically stated, " Do not use an extension cord. Failure to follow these instructions could result in death, fire or electrical shock. "</p> <p>c) The dining room ice machine was plugged into an extension cord.</p> <p>d) The electric bed was plugged into a power strip in resident room 41.</p> <p>e) A suction machine and feed pump were plugged into power strips in resident room 31.</p> <p>Based on interview at the time of observations, the Maintenance Director acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p>		<p>3-All items noted in the survey to be plugged into power strips (break room air conditioner, medical records and MDS portable air conditioners, dining room ice machine, room 41 electric bed, room 31 suction machine) were unplugged from power strips and plugged directly into electrical outlets. Maintenance Director in-serviced by ED on 7/6/15 on Life Safety Code regulation K147. All facility rooms/areas were audited to ensure that no other appliances were plugged into power strips.</p> <p>4-Maintenance Director or designee will conduct Preventative Maintenance Program routine rounds. Inappropriate items found to be plugged into power strips inappropriately will be unplugged from power strips and plugged into an appropriate outlet. All findings will be included in the facility's Continuous Quality Improvement program and the plan of action adjusted accordingly when 100% compliance is not achieved.</p> <p>Attachments B, C, D July 25, 2015</p>		