

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155667	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2016
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NAME OF PROVIDER OR SUPPLIER OAK GROVE CHRISTIAN RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 221 W DIVISION ST DEMOTTE, IN 46310
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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: 10/04/16</p> <p>Facility Number: 010823 Provider Number: 155667 AIM Number: 200236630</p> <p>At this Life Safety Code survey, Oak Grove Christian Retirement Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building identified as the Shepard's Care and Skilled units was located on the southeast and southwest wings of the first floor, built prior to March 1, 2003, and surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>The facility is located on the first floor of a two story fully sprinklered building of Type V (111) construction. The facility</p>	K 0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>Oak Grove Christian Retirement Village desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on November 3, 2016.</p> <p>The facility respectfully requests paper compliance. Please accept the attached as our credible allegation of 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 0017 SS=E Bldg. 01	<p>has a fire alarm system with hard wired smoke detection in the corridors, resident rooms and spaces open to the corridors. The facility has the capacity for 59 and had a census of 52 at the time of this survey.</p> <p>All areas where the residents have customary access and areas providing facility services were sprinklered.</p> <p>Quality Review completed on 10/06/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 1 Front Desk area was separated from the corridors by a partition capable of resisting the passage of smoke as required in a</p>	K 0017	It is the policy of this facility to ensure that all areas are separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an	11/03/2016

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K 0038 SS=E Bldg. 01	<p>sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by an automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect staff and up to 38 residents</p> <p>Findings include:</p> <p>Based on observation with the Plant Manager on 10/04/16 at 12:38 p.m., the Front Desk area was open to the corridor. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because the room was not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of observation, the Plant Manager acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are</p>		<p>Exception.</p> <p>I. <u>Specific Corrective Actions:</u></p> <p>The Front Desk area will be protected by an electrically supervised automatic smoke detection system.</p> <p>II. <u>Identification and correction of others:</u></p> <p>There are no other similar areas in the building.</p> <p>III. <u>Systemic Changes:</u></p> <p>All maintenance staff will attend an in-service reviewing the Standard and any exception.</p> <p>IV. <u>Monitoring:</u></p> <p>The plant manager or designee will do weekly checks, for one month, to ensure the smoke detector is installed and the electrically supervised automatic smoke detection system is working properly. The checks will then decrease to monthly for six months.</p>		

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	<p>readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation, record review, and interview, the facility failed to ensure 1 of 1 Oak Branch 2 Dining room and 1 of 1 Staff Break Room exits had a code posted. 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 unlock such doors at all times. This deficient practice could affect staff and up to 38 residents.</p> <p>Findings include:</p> <p>Based on observation with the Plant Manager on 10/04/16 at 11:55 a.m. then again at 12:26 p.m., the Oak Branch 2 Dining room and the Staff Break room entrance/exit doors were held in the locked position with a magnetic hold down device. Furthermore, both exit doors were equipped with an electronic keypad entry system that allowed staff to open the locked exit doors with a</p>	K 0038	<p>It is the policy of this facility to ensure that all access-controlled egress doors meet all requirements.</p> <p><u>I. Specific Corrective Actions:</u></p> <p>A Push To Exit sign will be added to the access-controlled egress exterior door near resident room 102 and any other identified doors.</p> <p><u>II. Identification and correction of others:</u></p> <p>All access-controlled egress exterior doors were checked to ensure that directions to egress were obvious to everyone, including the public.</p> <p><u>III. Systemic Changes:</u></p> <p>All maintenance staff will attend an in-service reviewing the Standard related to exit access being readily accessible at all times.</p> <p><u>IV. Monitoring:</u></p> <p>The plant manager or designee will do weekly checks, for one month, to ensure access-controlled egress exterior doors have a Push to Exit sign or an obvious keypad for egress.</p>	11/03/2016

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K 0048 SS=E Bldg. 01	<p>combination. A code was not posted at either entrance/exit door. Based on an interview at the time of observation, the Plant Manager acknowledged each 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. 19.7.1.1 Based on record review and interview, the facility failed to provide a written plan that addressed all components 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 staff and at least 18 residents.</p> <p>Findings include:</p>			K 0048	<p>The checks will then decrease to monthly for six months.</p> <p>It is the policy of this facility to have a written plan for the protection of all residents and for their evacuation in the event of an emergency.</p> <p><u>I. Specific Corrective Actions:</u></p> <p>The "Fire Door" designation on the Oak Leaf set of corridor doors was removed since the doors were not part of a complete barrier and could cause staff to evacuate residents to a different part of the same smoke compartment.</p> <p><u>II. Identification and correction of others:</u></p> <p>All sets of doors will be checked to ensure the designation of "Fire Door" is a true and accurate portrayal of that set of doors, and if not, that the designation is</p>		11/03/2016

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K 0054 SS=F Bldg. 01	<p>Based on a record review with the Plant Manager on 10/04/16 at 11:37 a.m., the facility had a written fire policy that horizontal evacuation would be performed by crossing fire doors. Based on observation, there were corridor doors that were not complete smoke or fire barriers which could cause staff to evacuate residents to a different part of the same smoke compartment and not to an adjacent compartment in the event of a fire. The Oak Branch 2 set of corridor doors contained a sign indicating "FIRE DOOR." Based on interview at the time of observation, the Plant Manager acknowledged the aforementioned condition and confirmed the doors were not part of a complete barrier.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm system was 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</p>	K 0054	<p>removed.</p> <p>III. Systemic Changes:</p> <p>All maintenance staff will attend an in-service to review the "Fire Door" designation only being used if the set of doors are part of a complete barrier.</p> <p>IV. Monitoring:</p> <p>The plant manager or designee will do weekly checks, for one month, to ensure all sets of doors are only designated as "Fire Door" if they are part of a complete barrier. The checks will then decrease to monthly for six months.</p> <p>It is the policy of this facility to ensure that all required smoke detectors are approved, maintained, inspected and tested in accordance with the manufacturer's specifications.</p> <p>I. Specific Corrective Actions: Sensitivity testing was</p>	11/03/2016			

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	<p>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> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (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 (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction 		<p>immediately scheduled for October 18, 2016. Documentation will be available for review after that date.</p> <p>II. Identification and correction of others: There were/are no other applicable reports not available for review.</p> <p>III. Systemic Changes: All maintenance staff will attend an in-service to review the need for documentation related to sensitivity reports.</p> <p>IV. Monitoring: The plant manager or designee will do weekly checks, for one month, to ensure all required documentation, especially sensitivity reports, are available for review. The checks will then decrease to monthly for six months.</p>		

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K 0072 SS=E Bldg. 01	<p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview at the time of record review on 10/04/16 at 1:00 p.m., the Plant Manager acknowledged no documentation for a sensitivity report was available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1</p> <p>Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 1 of 4 corridors. This deficient practice could affect staff, visitors, and at least 18 residents</p> <p>Findings include:</p>	K 0072	It is the policy of this facility to ensure that all means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility	11/03/2016

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	Based on observations with the Plant Manager on 10/04/16 at 11:40 a.m., one table and five separate recliners were stored in the Oak Branch 2 corridor. The furniture was not fixed to the wall or floor. The furniture was grouped in an area 46 inches by 17 feet. Based on interview at the time of observation, the Plant Manager acknowledged the aforementioned condition and provided the measurements. 3.1-19(b)				thereof shall be in accordance with 7.1.10. 18.2.1,19.2.1. I. Specific Corrective Actions: The dresser was relocated to ensure the means of egress is maintained free from obstructions. II. Identification and correction of others: All corridors were checked to ensure that means of egress are free from obstructions. III. Systemic Changes: All maintenance staff will attend an in-service to review the Standard related to means of egress being free from obstructions. IV. Monitoring: The plant manager or designee will do weekly checks, for one month, to ensure all means of egress are continuously maintained free from obstructions. The checks will then decrease to monthly for six months.		
K 0130 SS=E Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in 2 of 2 existing building fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3			K 0130	It is the policy of this facility to ensure that all penetrations in existing building fire barrier walls are maintained to ensure the fire resistance of the barrier.		11/03/2016

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	<p>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> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect 38 residents.</p> <p>Findings include:</p>		<p><u>I. Specific Corrective Actions:</u> The penetrations in Oak Branch I fire barrier, and around cables and inside conduit in the Oak Leaf barrier were filled with a documented fire stop material.</p> <p><u>II. Identification and correction of others:</u> All fire barriers were checked to ensure they contained no penetrations and if found that any penetration was filled with a documented fire stop material.</p> <p><u>III. Systemic Changes:</u> All maintenance staff will attend an in-service to review penetrations to fire barriers and the use of an approved/documented fire stop material.</p> <p><u>IV. Monitoring:</u> The plant manager or designee will do weekly checks, for one month, to ensure any penetration to any fire barrier is filled with an approved/documented fire stop material. The checks will then decrease to monthly for six months.</p>		

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K 0144 SS=C Bldg. 01	<p>Based on an observation with the Plant Manager on 10/04/16 at 12:41 p.m. then again at 12:45 p.m., a two inch by two inch penetration with expandable foam in Oak Branch 1 fire barrier. Then again, a one inch penetration around cables and a one inch gap inside conduit in the Oak Leaf fire barrier. Based on interview at the time of each observation, the Plant Manager acknowledged each aforementioned condition, provided the measurements and was unable to provide documentation demonstrating the expandable foam was tested as a through penetration fire stop material.</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>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</p>	K 0144	<p>It is the policy of this facility to ensure that generators are inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110.</p> <p>I. Specific Corrective Actions: The facility immediately included on the generator log the</p>	11/03/2016

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K 0147 SS=E Bldg. 01	<p>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 shutdown. 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 record review with the Plant Manager on 10/04/16 at 9:42 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 Plant Manager 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</p>		<p>requirement to allow a 5 minute cool down period after a load test.</p> <p>II. Identification and correction of others: There are no other generators or generator logs for this facility.</p> <p>III. Systemic Changes: All maintenance staff will attend an in-service to review the updated generator log and the requirement for a 5 minute cool down period after a load test.</p> <p>IV. Monitoring: The plant manager or designee will do weekly checks, for one month, to ensure that following each load test the generator is allowed a 5 minute cool down period. The checks will then decrease to monthly for six months.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155667	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2016
NAME OF PROVIDER OR SUPPLIER OAK GROVE CHRISTIAN RETIREMENT VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 221 W DIVISION ST DEMOTTE, IN 46310		
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	<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 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 residents.</p> <p>Findings include:</p> <p>Based on observation with the Plant Manager on 10/04/16 at 12:03 p.m. then again at 12:11 p.m., an extension cord was powering a computer monitor in the Social Service office. Then again, a surge protector was powering a refrigerator in resident room 130. Based on interview at the time of each observation, the Plant Manager acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>	K 0147	<p>It is the policy of this facility to ensure that electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2.</p> <p>I. <u>Specific Corrective Actions:</u></p> <p>a) The extension cord in the Social Service office was removed.</p> <p>b) The refrigerator in resident room 130 was unplugged from the surge protector and plugged directly into a wall outlet.</p> <p>II. <u>Identification and correction of others:</u></p> <p>All areas/rooms were checked to ensure that extension cords were not in use and that any surge protectors were being used in accordance with NFPA 70.</p> <p>III. <u>Systemic Changes:</u></p> <p>All maintenance staff will attend an in-service reviewing the prohibited use of extension cords and allowable use of surge protectors.</p> <p>IV. <u>Monitoring:</u></p> <p>The plant manager or designee will do weekly checks, for one month, to ensure extension cords are not in use and any surge protectors are being used</p>	11/03/2016	

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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: 10/04/16</p> <p>Facility Number: 010823 Provider Number: 155667 AIM Number: 200236630</p> <p>At this Life Safety Code survey, Oak Grove Christian Retirement Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The 2013 Oak Leaf Rehabilitation Unit was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>The Oak Leaf Unit is a one story fully sprinklered building of Type V (111) construction. The addition has a fire</p>	K 0000	<p>properly. The checks will then decrease to monthly for six months.</p> <p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>Oak Grove Christian Retirement Village desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on November 3, 2016.</p> <p>The facility respectfully requests paper compliance. Please accept the attached as our credible allegation of compliance.</p>	

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K 0038 SS=E Bldg. 02	<p>alarm system with hard wired smoke detection in the resident rooms and in the corridor at the horizontal exit. The facility has the capacity for 59 and had a census of 52 at the time of this survey.</p> <p>All areas where the residents have customary access and areas providing facility services were sprinklered.</p> <p>Quality Review completed on 10/06/16 - 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, the facility failed to ensure 1 of 1 access-controlled egress door met all requirements. LSC 18.2.2.2.3 exception 3 states access-controlled egress doors to comply with 7.2.1.6.2. LSC 7.2.1.6.2 requires (a) a sensor shall be provided on the egress side and arranged to detect an occupant approaching the doors, and the doors shall be arranged to unlock in the direction of egress upon detection of an approaching occupant or loss of power to the sensor. (b) loss of power to the part of the access control system that locks the doors shall automatically unlock the doors in the direction of egress. (c) the doors shall be arranged to unlock in the</p>	K 0038	<p>It is the policy of this facility to ensure that all access-controlled egress doors meet all requirements.</p> <p>I. <u>Specific Corrective Actions:</u></p> <p>A Push To Exit sign will be added to the access-controlled egress exterior door near resident room 102 and any other identified doors.</p> <p>II. <u>Identification and correction of others:</u></p> <p>All access-controlled egress exterior doors were checked to ensure that directions to egress</p>	11/03/2016

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	<p>direction of egress from a manual release device located 40 in to 48 in vertically above the floor and within 5 feet of the secured doors. The manual release device shall be readily accessible and clearly identified by a sign that reads as follows: PUSH TO EXIT. When operated, the manual release device shall result in direct interruption of power to the lock - independent of the access control system electronics - and the doors shall remain unlocked for not less than 30 seconds. (d)Activation of the building fire-protective signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. (e) Activation of the building automatic sprinkler or fire detection system, if provided, shall automatically unlock the doors in the direction of egress and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice could affect staff and up to 5 residents.</p> <p>Findings include:</p> <p>Based on observation with the Plant Manager on 10/04/16 at 10:31 a.m., the access-controlled egress exterior exit door near resident room 102 only</p>		<p>were obvious to everyone, including the public.</p> <p>III. Systemic Changes:</p> <p>All maintenance staff will attend an in-service reviewing the Standard related to exit access being readily accessible at all times.</p> <p>IV. Monitoring:</p> <p>The plant manager or designee will do weekly checks, for one month, to ensure access-controlled egress exterior doors have a Push to Exit sign or an obvious keypad for egress. The checks will then decrease to monthly for six months.</p>				

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K 0039 SS=E Bldg. 02	<p>included an access-controlled sensor. Based on interview at the time of observation, the Plant Manager acknowledged the aforementioned condition and confirmed that directions to egress were not obvious to the public.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4</p> <p>Based on observation, the facility failed to ensure 1 of 2 exit access corridors had a clear and unobstructed exit width of at least 8 feet. LSC 18.2.3.3 requires aisles, corridors, and ramps required for exit access in a nursing home shall be not less than 8 ft in clear and unobstructed width. This deficient practice could affect staff and up to 5 residents.</p> <p>Findings include:</p> <p>Based on observation with the Plant Manager on 10/04/16 at 10:31 a.m., there was a dresser in the corridor against the railing outside resident room 102. A table</p>	K 0039	<p>It is the policy of this facility to ensure that width of aisles or corridors serving exit access shall be at least eight (8) feet.</p> <p>I. <u>Specific Corrective Actions:</u></p> <p>The dresser, table and set of chairs were relocated to ensure an unobstructed exit access corridor width of at least eight (8) feet.</p> <p>II. <u>Identification and correction of others:</u></p> <p>All exit access corridors were checked to ensure an</p>	11/03/2016

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K 0048 SS=E Bldg. 02	<p>and set of chairs were in the corridor against the railing outside resident room 102. The most restrictive width between the dress and a chair was thirty eight inches of clear unobstructed width. Based on interview at the time of observation, the Plant Manager acknowledged the aforementioned condition and provided the measurement.</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 Based on record review and interview, the facility failed to provide a written plan that addressed all components 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: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms</p>	K 0048	<p>unobstructed width of at least eight (8) feet.</p> <p>III. Systemic Changes: All maintenance staff will attend an in-service reviewing that width of aisles or corridors serving exit access shall be at least eight (8) feet.</p> <p>IV. Monitoring: The plant manager or designee will do weekly checks, for one month, to ensure that width of aisles or corridors serving exit access are at least eight (8) feet. The checks will then decrease to monthly for six months.</p> <p>It is the policy of this facility to have a written plan for the protection of all residents and for their evacuation in the event of an emergency.</p> <p>I. Specific Corrective Actions: The "Fire Door" designation on the Oak Leaf set of corridor doors was removed since the doors were not part of a complete barrier and could cause staff to evacuate residents to a different</p>	11/03/2016

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K 0052 SS=E Bldg. 02	<p>(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 This deficient practice could affect staff and at least 5 residents.</p> <p>Findings include:</p> <p>Based on a record review with the Plant Manager on 10/04/16 at 10:14 a.m., the facility had a written fire policy that horizontal evacuation would be performed by crossing fire doors. Based on observation, there were corridor doors that were not complete smoke or fire barriers which could cause staff to evacuate residents to a different part of the same smoke compartment and not to an adjacent compartment in the event of a fire. The Oak Leaf set of corridor doors contained a sign indicating "FIRE DOOR." Based on interview at the time of observation, the Plant Manager acknowledged the aforementioned condition and confirmed the doors were not part of a complete barrier.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety</p>		<p>part of the same smoke compartment.</p> <p>II. Identification and correction of others:</p> <p>All sets of doors will be checked to ensure the designation of "Fire Door" is a true and accurate portrayal of that set of doors, and if not, that the designation is removed.</p> <p>III. Systemic Changes:</p> <p>All maintenance staff will attend an in-service to review the "Fire Door" designation only being used if the set of doors are part of a complete barrier.</p> <p>IV. Monitoring:</p> <p>The plant manager or designee will do weekly checks, for one month, to ensure all sets of doors are only designated as "Fire Door" if they are part of a complete barrier. The checks will then decrease to monthly for six months.</p>		

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	<p>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 and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7,</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was provided in accordance with Section 9.6. Section 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, Section 2-8.2.1 states that manual fire alarm boxes shall be located throughout the protected area so that they are unobstructed and accessible. This deficient practice could affect staff and at least 9 residents.</p> <p>Findings include:</p> <p>Based on observation with the Plant Manager on 10/04/16 at 10:48 a.m., there was a LiteGait physical therapy lift stored in front of a pull station. Based on interview at the time of observation, the Plant Manager acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0052	<p>It is the policy of this facility to ensure that the fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA72 National Fire Alarm Code.</p> <p><u>I. Specific Corrective Actions:</u></p> <p>The LiteGait was immediately relocated to a location where it was not in front of a fire pull station.</p> <p><u>II. Identification and correction of others:</u></p> <p>All locations of fire pull stations were checked to ensure none were blocked by a piece of equipment or anything else.</p> <p><u>III. Systemic Changes:</u></p> <p>All maintenance staff will attend an in-service reviewing that fire pull stations may not be blocked at anytime.</p> <p><u>IV. Monitoring:</u></p>	11/03/2016

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K 0072 SS=E Bldg. 02	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1</p> <p>Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 1 of 2 corridors. This deficient practice could affect staff, visitors, and at least 5 residents</p> <p>Findings include:</p> <p>Based on observations with the Plant Manager on 10/04/16 at 10:31 a.m., a dresser was stored in the corridor against the railing outside resident room 102. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0072	<p>The plant manager or designee will do weekly checks, for one month, to ensure fire pull stations are not blocked. The checks will then decrease to monthly for six months.</p> <p>It is the policy of this facility to ensure that all means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1,19.2.1.</p> <p>I. <u>Specific Corrective Actions:</u> The dresser was relocated to ensure the means of egress is maintained free from obstructions.</p> <p>II. <u>Identification and correction of others:</u> All corridors were checked to ensure that means of egress are</p>	11/03/2016

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K 0076 SS=E Bldg. 02	<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 "storage room across from elevator equipment room" of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or</p>	K 0076	<p>free from obstructions.</p> <p>III. Systemic Changes: All maintenance staff will attend an in-service to review the Standard related to means of egress being free from obstructions.</p> <p>IV. Monitoring: The plant manager or designee will do weekly checks, for one month, to ensure all means of egress are continuously maintained free from obstructions. The checks will then decrease to monthly for six months.</p> <p>It is the policy of this facility to ensure that medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</p>	11/03/2016	

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K 0144 SS=C Bldg. 02	<p>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 and up to 5 residents.</p> <p>Findings include:</p> <p>Based on observation with the Plant Manager on 10/04/16 at 11:20 a.m., the "storage room across from elevator equipment room: had one oxygen cylinder that was freestanding on the floor. Based on interview at the time of observation, the Plant Manager acknowledged the aforementioned condition.</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) Based on record review and interview, the facility failed to ensure 1 of 1</p>	K 0144	<p>I. <u>Specific Corrective Actions:</u></p> <p>The freestanding oxygen cylinder was immediately removed.</p> <p>II. <u>Identification and correction of others:</u></p> <p>All storage rooms were checked to ensure that no freestanding oxygen cylinders were stored in them.</p> <p>III. <u>Systemic Changes:</u></p> <p>All maintenance staff will attend an in-service reviewing the prohibited storage of freestanding oxygen cylinders.</p> <p>IV. <u>Monitoring:</u></p> <p>The plant manager or designee will do weekly checks, for one month, to ensure oxygen cylinders are not stored inappropriately. The checks will then decrease to monthly for six months.</p> <p>It is the policy of this facility to ensure that generators are</p>	11/03/2016			

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	<p>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 shutdown. 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 record review with the Plant Manager on 10/04/16 at 9:42 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 Plant Manager acknowledged the aforementioned condition.</p>		<p>inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110.</p> <p><u>I. Specific Corrective Actions:</u> The facility immediately included on the generator log the requirement to allow a 5 minute cool down period after a load test.</p> <p><u>II. Identification and correction of others:</u> There are no other generators or generator logs for this facility.</p> <p><u>III. Systemic Changes:</u> All maintenance staff will attend an in-service to review the updated generator log and the requirement for a 5 minute cool down period after a load test.</p> <p><u>IV. Monitoring:</u> The plant manager or designee will do weekly checks, for one month, to ensure that following each load test the generator is allowed a 5 minute cool down period. The checks will then decrease to monthly for six months.</p>				

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K 0018 SS=E Bldg. 03	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Riser Room positively latched into the door frame. This deficient practice could affect staff and at least 9 residents.</p> <p>Findings include:</p> <p>Based on observation with the Plant Manager on 10/04/16 at 11:10 a.m., the Riser room contained a set of double doors. Both doors latched into each other, but one door contained manual latching hardware. Based on interview at the time of observation, the Plant Manager acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0018	<p>It is the policy of this facility to ensure that doors protecting corridor openings shall be constructed to resist the passage of smoke and that there is no impediment to the closing of the doors and that doors are provided with positive latching hardware.</p> <p>I. <u>Specific Corrective Actions:</u></p> <p>The manual latching hardware on the Riser Room doors on Oak Leaf was changed to positive latching hardware.</p> <p>II. <u>Identification and correction of others:</u></p> <p>All corridor doors were checked to ensure they had positive latching hardware.</p> <p>III. <u>Systemic Changes:</u></p>	11/03/2016	

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K 0038 SS=E Bldg. 03	<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</p> <p>Based on observation, the facility failed to ensure 3 of 4 access-controlled egress doors met all requirements. LSC 19.2.2.2.3 exception 3 states access-controlled egress doors to comply with 7.2.1.6.2. LSC 7.2.1.6.2 requires (a) a sensor shall be provided on the egress side and arranged to detect an occupant approaching the doors, and the doors shall be arranged to unlock in the direction of egress upon detection of an approaching occupant or loss of power to the sensor. (b) loss of power to the part of the access control system that locks the doors shall automatically unlock the doors in the direction of egress. (c) the</p>	K 0038	<p>All maintenance staff will attend an in-service reviewing the use of positive latching hardware on doors protecting corridor openings.</p> <p>IV. Monitoring:</p> <p>The plant manager or designee will do weekly checks, for one month, to ensure all doors protecting corridor openings have positive latching hardware. The checks will then decrease to monthly for six months.</p> <p>It is the policy of this facility to ensure that all access-controlled egress doors meet all requirements.</p> <p>I. Specific Corrective Actions:</p> <p>A Push To Exit sign will be added to the access-controlled egress exterior door near resident room 102 and any other identified doors.</p> <p>II. Identification and correction of others:</p> <p>All access-controlled egress exterior doors were checked to</p>	11/03/2016

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	<p>doors shall be arranged to unlock in the direction of egress from a manual release device located 40 in to 48 in vertically above the floor and within 5 ft of the secured doors. The manual release device shall be readily accessible and clearly identified by a sign that reads as follows: PUSH TO EXIT. When operated, the manual release device shall result in direct interruption of power to the lock - independent of the access control system electronics - and the doors shall remain unlocked for not less than 30 seconds.</p> <p>(d)Activation of the building fire-protective signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. (e) Activation of the building automatic sprinkler or fire detection system, if provided, shall automatically unlock the doors in the direction of egress and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice could affect staff and up to 9 residents.</p> <p>Findings include:</p> <p>Based on observation with the Plant Manager on 10/04/16 between 9:55 a.m. and 1:00 p.m., four access-controlled</p>		<p>ensure that directions to egress were obvious to everyone, including the public.</p> <p>III. Systemic Changes:</p> <p>All maintenance staff will attend an in-service reviewing the Standard related to exit access being readily accessible at all times.</p> <p>IV. Monitoring:</p> <p>The plant manager or designee will do weekly checks, for one month, to ensure access-controlled egress exterior doors have a Push to Exit sign or an obvious keypad for egress. The checks will then decrease to monthly for six months.</p>		

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	<p>egress exterior exit doors were discovered in the new health care occupancy. One of the four access-controlled egress exterior exit doors also contained a delayed egress lock which unlocked when tested. Based on interview at the time of observation, the Plant Manager acknowledged the aforementioned condition and confirmed that three doors failed to include directions to egress which were not obvious to the public.</p> <p>3.1-19(b)</p>			