

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
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NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403
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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: 10/24/14</p> <p>Facility Number: 000007 Provider Number: 155019 AIM Number: 100275040</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Garden Villa-Bloomington 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 portion of the facility was surveyed with Chapter 19, Existing Health Care Occupancies and included everything except the Dining/Lounge area on Station 3 and the renovated Sunroom on Station 1.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire</p>	K010000		

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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K010029 SS=D	<p>alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in resident sleeping rooms 101 through 126, 201 through 216 and 301 through 339. The facility has smoke detectors hard wired to the fire alarm system in resident sleeping rooms on Unit 4, 5, and 6. The facility has a capacity of 224 and had a census of 184 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 two detached storage buildings.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 11/05/14.</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 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved</p>			

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	<p>automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 16 hazardous areas such as fuel fired heater rooms were separated from other spaces by smoke resistant partitions and doors. This deficient practice could affect four staff and visitors in the vicinity of the Main Mechanical Room.</p> <p>Findings include:</p> <p>Based on observation with the Physical Plant Supervisor during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/24/14, an eight foot high by four foot wide section of the inside wall of south wall of the Main Mechanical Room by the kitchen was missing which exposed three wood studs and did not ensure the room was separated from other spaces by smoke resistant partitions. The aforementioned room contained a natural gas fired boiler. Based on interview at the time of observation, the Physical Plant Supervisor acknowledged the Main</p>	K010029	<p>We respectfully submit this plan of correction as proof of our compliance with State and Federal regulations, and per the laws that mandate the submission of this plan. We respectfully request a desk review/paper compliance for the plan of correction submitted. Please review the attached documents with this plan of correction, as evidence of completion of this plan of correction and evidence of compliance. I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected regarding this citing. The wall in question was replaced with 5/8th dry wall. This smoke resistant partition will protect the staff and visitors in this vicinity. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents, staff and visitors have the potential to be</p>	10/27/2014			

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K010038 SS=E	<p>Mechanical Room by the kitchen was not separated from other spaces by smoke resistant partitions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 13 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. 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 states door-locking arrangements without</p>	K010038	<p>affected by missing smoke resistant partitions or doors. All areas have been inspected and are in place and secure. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? If at any time a smoke barrier wall or partition wall is dismantled, that wall will be replaced and will be on smoke watch till completed. Maintenance Supervisor will ensure this new protocol. IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur? The Maintenance Supervisor ensures that all walls are in tact and he is the only staff that could allow dismantlement, therefore ensuring that the walls are in place at all times.</p> <p>I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents able to use a coded door will have the information needed as this is now posted next to the exit. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the</p>	10/27/2014

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	<p>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 14 residents, staff and visitors if needing to exit the facility by the Station 1 Day Room.</p> <p>Findings include:</p> <p>Based on observation with the Physical Plant Supervisor during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/24/14, the Station 1 Day Room exit was marked as a facility exit, the exit door was magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of observation, the Physical Plant Supervisor acknowledged the four digit code was not posted at the Station 1 Day Room exit. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview,</p>		<p>potential to be affected. The cited exit has been corrected. All exits have been inspected and are functioning properly and/or labeled correctly. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? All exits and door function are on a Preventative Maintenance monthly inspection. This inspection involves physically looking at and inspecting the exit and magnetic function for proper operation and labeling. IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur? All exits and door function are on a Preventative Maintenance monthly inspection. This inspection involves physically looking at and inspecting the exit and magnetic function for proper operation and labeling. All Preventative Maintenance logs will be turned in to Quality Assurance monthly for review.</p>	

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	<p>the facility failed to ensure the means of egress through 1 of 13 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. 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 states 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. LSC 19.2.2.2.5 states doors located in the means of egress that are permitted to be locked shall have adequate provisions made for the rapid removal of occupants by means such as keying of all locks to keys carried by staff at all times, or other such reliable means available to staff at all times. This deficient practice could affect 14 residents, staff and visitors if needing to exit the facility by the Station 1 Day Room.</p> <p>Findings include:</p> <p>Based on observation with the Physical Plant Supervisor during a tour of the facility from 12:45 p.m. to 3:45 p.m. on</p>			

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K010048 SS=D	<p>10/24/14, the Station 3 South Dining Room exit was marked as a facility exit, the exit door was locked and could be opened by using a key posted at the exit to unlock the door but the tumbler inside the locking device malfunctioned which caused the door to fail to unlock. Based on interview at the time of observation, the Physical Plant Supervisor stated the tumbler inside the locking device failed to unlock the door when the key was inserted and turned and acknowledged the Station 3 South Dining Room exit door failed to unlock.</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, observation and interview; the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p>	K010048	<p>I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected, but with potential to affect staff. The use of the Class K extinguisher was posted in the kitchen but was not in the</p>	11/21/2014			

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	<p>(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 This deficient practice could affect three kitchen staff.</p> <p>Findings include:</p> <p>Based on review of "Emergency Manual" and "Operational/Emergency Policy & Procedure Manual: Fire Safety" documentation with the Physical Plant Supervisor during record review from 9:45 a.m. to 12:00 p.m. on 10/24/14, the fire disaster plan did not address the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on observation with the Physical Plant Supervisor during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/24/14, a K class fire extinguisher was located in the kitchen. Based on interview at the time of record review, the Physical Plant Supervisor acknowledged the written fire safety plan for the facility did not include kitchen</p>		<p>Emergency Manual. The Emergency Manual has been updated to include the Class K fire extinguisher and its use. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All resident, staff and visitors have the potential to be affected. All Emergency Manuals in the facility have been updated to include the Class K fire extinguisher use. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The Emergency Manual is on the Preventative Maintenance inspection/update list annually. This will be completed by the Maintenance Supervisor and /or his designee. IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur? The Emergency Manual is on the Preventative Maintenance inspection/update list annually. This will be completed by the Maintenance Supervisor and /or his designee. All Preventative Maintenance logs will be turned in to Quality Assurance monthly for review.</p>				

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K010068 SS=D	<p>staff training to activate the overhead hood extinguishing system to suppress a fire before using the K class fire extinguisher.</p> <p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 fuel fired heater rooms in the Laundry was provided with intake combustion air taken directly from the outside. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for four staff in the laundry.</p> <p>Findings include:</p> <p>Based on observation with the Physical Plant Supervisor during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/24/14, the Laundry contained three natural gas fired dryers and it could not be assured the Laundry was provided with intake combustion air taken directly from the outside at all times. An open window in the wall next to the dryers was observed but the window can be closed. Based on interview at the time of</p>	K010068	<p>I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this citing. To correct this citing a square damper was installed into the wall from the outside in to allow for constant fresh air. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? No resident would be affected as this is a employee only area, however staff could be affected. To correct this citing a square damper was installed into the wall from the outside in to allow for constant fresh air. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The damper has been added to the Preventative Maintenance inspection for weekly inspection. This will ensure constant air exchange.</p>	10/28/2014

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K010072 SS=E	<p>observation, the Physical Plant Supervisor acknowledged it could not be assured the Laundry was provided with intake combustion air taken directly from the outside at all times should the window be closed.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are 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 obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure 2 of 13 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 22 residents, staff and visitors if needing to exit the facility by Room 601.</p> <p>Findings include:</p> <p>Based on observations with the Physical Plant Supervisor during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/24/14, the following was noted: a. the vestibule for the exit by Room 601 is marked with an exit sign as a facility</p>	K010072	<p>IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur? The damper has been added to the Preventative Maintenance inspection for weekly inspection. This will ensure constant air exchange. All Preventative Maintenance logs will be turned in to Quality Assurance monthly for review.</p> <p>I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The vestibule area has been cleared of any obstruction and the outside egress area has had orange cones placed in the lined areas to keep this area clear. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents in this area have the potential to be affected. The vestibule area will remain free of obstruction and the outside lot egress will remain marked with cones, lined for no parking and signage will remain stating such.</p>	10/28/2014			

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K010130 SS=E	<p>exit and two wooden pallets, 5 large boxes filled with paper, ten framed pictures and four mirrors were being stored in the vestibule.</p> <p>b. two cars were parked outside the building blocking the path of egress for the exit discharge by Room 601. The area outside the building in the path of egress was marked with a "No Parking" sign and the pavement was painted as a no parking area but two cars were observed parked in this no parking area.</p> <p>c. the vestibule for the service hall exit is marked with an exit sign as a facility exit and six 32 gallon containers with clean mop heads were being stored in the vestibule for the service hall exit. Based on interview at the time of the observations, the Physical Plant Supervisor acknowledged the aforementioned exits are marked with an exit sign as facility exits but each means of egress was not maintained free of all obstructions to instant use.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 1 of 81 resident</p>	K010130	<p>III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The vestibule area will remain free of obstructions and the outside egress will continue to have cones, signs and lined lot to ensure the area is free of impediments. These areas have been added to the Preventative Maintenance inspection weekly sheet. This inspection will be done by maintenance staff. IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur? The vestibule area will remain free of obstructions and the outside egress will continue to have cones, signs and lined lot to ensure the area is free of impediments. These areas have been added to the Preventative Maintenance inspection weekly sheet. This inspection will be done by maintenance staff. All Preventative Maintenance logs will be turned in to Quality Assurance monthly for review.</p> <p>I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected but with potential to be affected. The</p>	11/06/2014

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	<p>sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect 26 residents, staff and visitors in the vicinity of Room 339.</p> <p>Findings include:</p> <p>Based on review of the floor plan of the facility and "Plant Operations Monthly Preventive Maintenance Checks & Services" with the Physical Plant Supervisor during record review from 9:45 a.m. to 12:00 p.m. on 10/24/14, resident sleeping Room 339 was not included in the itemized listing of battery operated smoke detector testing for January 2014 through September 2014. Based on interview at the time of record review, the Physical Plant Supervisor stated the battery operated smoke detectors are required to be function tested monthly, no additional battery operated smoke detector testing documentation was available for review and acknowledged battery operated smoke detector testing documentation for January 2014 through September 2014 for Room 339 was not available for review. Based on observation with the Physical Plant Supervisor during a tour of the facility from 12:45 p.m. to 3:45 p.m.</p>		<p>Preventative Maintenance inspection log has been corrected to include room 339. The smoke detectors in rooms 311, 313, 324, 323, 325, 326 have been relocated at least 3 feet from the air supply. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the practice. All other smoke detectors are on the inspection list and located properly in the rooms. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? All smoke detectors are on the Preventative Maintenance inspection sheet for monthly inspection. IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur? The Preventative Maintenance logs will be turned in to Quality Assurance monthly for review.</p>				

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>on 10/24/14, a battery operated smoke detector was installed in Room 339.</p> <p>3.1-19(a)</p> <p>2. Based on observation and interview, the facility failed to install 6 of 81 battery operated smoke detectors in accordance with NFPA 72. 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. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect 12 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Physical Plant Supervisor during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/24/14, the battery operated smoke detectors in Room 311, 313, 323, 324, 325 and 326 were each installed on the wall eight inches below a mechanically assisted air return opening on the ceiling. Based on interview at the time of</p>			

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K010147 SS=D	<p>observation, the Physical Plant Supervisor acknowledged each of the aforementioned smoke detectors were installed on the wall less than three feet from an air return opening.</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 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect four staff in the Laundry.</p> <p>Findings include:</p> <p>Based on observation with the Physical Plant Supervisor during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/24/14, a name tag pressing machine was plugged into a power strip which was plugged into an extension cord behind the dryers in the Laundry. Based on interview at the time of observation, the Physical Plant Supervisor</p>	K010147	<p>I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this practice. The extension cord was removed and a new, longer electrical supply cord was placed on the labeling machine to allow a direct plug in. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? No residents were affected by this practice. The extension cord was removed and a new, longer electrical supply cord was placed on the labeling machine to allow a direct plug in. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? An electrical cord check has been added to the Preventative Maintenance sheet for weekly inspection. IV. How</p>	11/20/2014

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K030000	<p>acknowledged a power strip and an extension cord were utilized as a substitute for fixed wiring in the Laundry.</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: 10/24/14</p> <p>Facility Number: 000007 Provider Number: 155019 AIM Number: 100275040</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Garden Villa-Bloomington 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</p>	K030000	<p>corrective action(s) will be monitored to ensure the deficient practice will not recur? The Preventative Maintenance logs will be turned in to Quality Assurance monthly for review. In addition, a memo was posted on all units and given to all directors indicating that any use of an electrical cord must be approved for use by maintenance prior to its use.</p>	

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	<p>16.2. The 2013 addition to the facility was surveyed with Chapter 18, New Health Care Occupancies for the Dining/Lounge area on Station 3 and the renovated Sunroom on Station 1.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in resident sleeping rooms 101 through 126, 201 through 216 and 301 through 339. The facility has smoke detectors hard wired to the fire alarm system in resident sleeping rooms on Unit 4, 5, and 6. The facility has a capacity of 224 and had a census of 184 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 two detached storage buildings.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K030038 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. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 13 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 18.2.2.2.4 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 states 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 14 residents, staff and visitors if needing to exit the facility by the Therapy Room.</p> <p>Findings include: Based on observation with the Physical</p>	K030038	<p>I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents able to use a coded door will have the information needed as this is now posted next to the exit. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected. The cited exit has been corrected. All exits have been inspected and are functioning properly and/or labeled correctly. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? All exits and door function are on a Preventative Maintenance monthly inspection. This inspection involves physically looking at and inspecting the exit and magnetic function for proper operation and labeling. IV. How corrective action(s) will be monitored to ensure the deficient</p>	10/27/2014

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	Plant Supervisor during a tour of the facility from 12:45 p.m. to 3:45 p.m. on 10/24/14, the Therapy Room exit was marked as a facility exit, the exit door was magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of observation, the Physical Plant Supervisor acknowledged the four digit code was not posted at the Therapy Room exit. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code. 3.1-19(b)		practice will not recur? All exits and door function are on a Preventative Maintenance monthly inspection. This inspection involves physically looking at and inspecting the exit and magnetic function for proper operation and labeling. All Preventative Maintenance logs will be turned in to Quality Assurance monthly for review.				