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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155479 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>02/06/2014 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>KINGSTON CARE CENTER OF FORT WAYNE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1010 W WASHINGTON CENTER RD<br>FORT WAYNE, IN 46825 |
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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 |
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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: 02/06/14</p> <p>Facility Number: 000522<br/>Provider Number: 155479<br/>AIM Number: 100267040</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Kingston Care Center of Fort Wayne 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 with 410 IAC 16.2. The original building consisting of the main entrance and the center service hall was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and was</p> | K010000 | <p>Enclosed is the plan of correction for the life safety survey completed at Kingston Care Center on 2/6/2014 . Please consider this the facility's credible allegation of compliance. However, submission of this response and the plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly rendered, and is also not to be constructed as an admission of interest against the facility, the administrator or any employees, agent, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set fourth in the allegation by the survey agency. Rather, this plan of correction has been prepared because the law requires us to prepare a plan of correction for the citations regardless of weather we agree with them. Kingston Care Center is requesting that a desk review be done for the plan of correction.</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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|                    | <p>fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors and hard wired smoke detector in all resident rooms except resident rooms 401 to 405 where battery operated smoke detector have been installed. The facility has a capacity of 137 and had a census of 116 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had a detached unsprinklered storage building providing facility services which was used for the storage of mowing equipment.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/17/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> |               |   |                      |

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| K010047<br>SS=E  | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1<br/>Based on observation and interview, the facility failed to ensure 1 of 1 doors likely to be mistaken for a way of exit was identified as "No Exit". LSC 7.10.8.1 requires any door that is neither an exit or a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall be identified by a sign that reads; NO EXIT. This deficient practice could affect at least 30 residents in the Royal Cafe dining room.</p> <p>Findings include:</p> <p>Based on observation and interview with the Environmental Services Supervisor on 02/06/14 at 2:10 p.m., one side door in the Royal Cafe dining room lead outside into an enclosed courtyard and was not considered an emergency exit. There was no sign identifying the door as "NO EXIT" for emergency purposes.</p> <p>3.1-19(b)</p> | K010047   | The property installed a "NOT AN EXIT" sign with 3" red letters, on the door in the Royal Café dining room leading out to the courtyard, as well on the door in the 200 hall therapy room leading to the courtyard. This was an oversight during the 2012/13 construction. The maintenance department will monitor the placement of the signs and document this on the monthly maintenance log during the morning maintenance rounds. (See Attachment) | 03/13/2014   |  |   |  |

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| K010050<br>SS=F  | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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>1. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Fire Drill Report" with the Environmental Services Supervisor on 02/06/14 at 11:45 a.m., there was no record of a third shift fire drill for the fourth quarter of 2013. Based on an interview with the Environmental Services Supervisor at the time of record review, no other documentation was available for review to verify this drill was conducted.</p> <p>3.1-19(b)<br/>3.1-51(c)</p> | K010050   | The property maintenance department modified the "facility fire Drill Report" to include location, and type of fire. The facility maintenance department also implemented a fire drill annual schedule. The fire drill schedule and report will be monitored by both the facility maintenance manager, and facility administrator. The fire drill report will be reviewed and signed on a monthly basis by the maintenance manager, and administrator. (See Attachment) | 03/13/2014   |  |   |  |

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| K010062<br>SS=E  | <p>2. Based on record review and interview, the facility failed to include the fire drill location and type of fire for 12 of the last 12 calendar months. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Fire Drill Report" with the Environmental Services Director on 02/06/14 at 11:55 a.m., the fire drill documentation did not include the location of the fire drill and the type of fire simulated. This was acknowledged by the Environmental Services Director at the time of record review.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to replace the corroded sprinkler heads in 1 of 1 main entrance canopies. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the</p> | K010062   | Shambaugh and Sons sprinkler division removed the sprinkler heads in question under the canopy located at the CCU entrance, and replaced with all but two of the six head with new non corrosive sprinkler heads on 02/27/14. The additional heads where installed on 03/13/14 due | 03/13/2014   |  |   |  |

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|  | <p>Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect residents in 1 of 10 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Supervisor on 02/06/14 at 12:10 p.m., the six sprinkler heads in the main entrance canopy were corroded with a green substance. This was acknowledged by the Environmental Services Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 sprinkler heads in the employee locker room was unobstructed. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray</p> |   | <p>to the material being back ordered. Shambaugh and Sons added a sprinkler head in the break room closet at other side of obstruction to ensure 100% full coverage on 2/27/14. Shambaugh and Sons added a sprinkler head in the shower room located on the 100 hall on 02/27/14. The shower room has 100% sprinkler coverage. Sprinkler head coverage and questionable corrosion will be monitored and documented by Shambaugh and Sons on a quarterly basis. The facility maintenance department will visually inspect all outdoor sprinkler heads on a quarterly basis, and document the findings on the outdoor sprinkler head pm summary. (See Attachment)</p> |  |  |   |  |

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| K010067<br>SS=E  | <p>patterns shall be corrected. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Supervisor on 02/06/14 at 2:18 p.m., the spray pattern for the sprinkler head in the employee locker room was obstructed by a wall which extends to the ceiling separating the lockers. The Environmental Services Supervisor stated the wall would obstruct the sprinkler spray pattern in the employees locker room.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 6 egress corridors were not being used as a portion of a return air system/plenum for air conditioning, heating and ventilating (HVAC) duct work serving adjoining areas. NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilation Systems, at 2-3.11.1 requires</p> | K010067   | Waiver (See Attachment)   | 03/12/2014           |   |

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| K010069<br>SS=D  | <p>egress corridors shall not be used as a portion of a supply, return or exhaust air system serving adjoining areas. This deficient practice could affect 2 of 10 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation and interview with the Environmental Services Director and the Maintenance Assistant on 02/06/14 from 11:30 a.m. to 3:16 p.m., resident rooms 401 through 405 and the common center hall were using the egress corridors as a return air system.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96<br/>Based on observation and interview, the facility failed to ensure 1 of 2 manual hood fire extinguishing activation devices was located in the path of egress. Section 9.2.3 requires commercial cooking equipment to be in compliance with NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations.<br/>NFPA 96 at Section 7-5.1 states a readily accessible means for manual</p> | K010069   | The facility contracted Shambaugh and Sons to install an additional hood extinguishing "in case of fire pull" station located inside the kitchen next to the Royal Café egress door. This was completed on 3/03/14. | 03/03/2014   |  |   |  |

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| K020000            | <p>activation shall be located between 42 inches and 60 inches above the floor, located in a path of exit or egress, and clearly identify the hazard protected. This deficient practice was not in a resident area but could affect kitchen staff.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Supervisor on 02/06/14 at 2:14 p.m., the activation device for the Royal Cafe kitchen hood fire protection system was mounted on the wall in the back of the kitchen. The emergency exits from the kitchen were at the front and side of the kitchen. This was acknowledged by the Environmental Services Supervisor at the time.</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: 02/06/14</p> | K020000       | Enclosed is the plan of correction for the life safety survey completed at Kingston Care Center on 2/6/2014 . Please consider this the facility's credible allegation of compliance. However, submission of this response and the plan of |                      |

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|  | <p>Facility Number: 000522<br/>Provider Number: 155479<br/>AIM Number: 100267040</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Kingston Care Center of Fort Wayne 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 with 410 IAC 16.2. The new sections consisting of the 100, 200, 300 and 400 halls was surveyed with Chapter 18, New Health Care Occupancies.</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, in areas open to the corridors and hard wired smoke detector in all resident rooms except resident rooms 401 to 405 where battery operated smoke detector have been installed. The facility has a capacity of 137 and had a census of 116 at the time of this survey.</p> |   | <p>correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly rendered, and is also not to be constructed as an admission of interest against the facility, the administrator or any employees, agent, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set fourth in the allegation by the survey agency. Rather, this plan of correction has been prepared because the law requires us to prepare a plan of correction for the citations regardless of weather we agree with them. Kingston Care Center is requesting that a desk review be done for the plan of correction.</p> |  |  |   |  |

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| K020018<br>SS=E  | <p>All areas where the residents have customary access were sprinklered. The facility had a detached unsprinklered storage building providing facility services which was used for the storage of mowing equipment.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3<br/>Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 mechanical rooms on the 200A hall closed and latched into the door frame. This deficient practice affects 31 residents on the 200A hall.</p> <p>Findings includes:</p> <p>Based on observation with the Environmental Services Supervisor on 02/06/14 at 1:30 p.m., the 200A hall mechanical room was provided with double corridor doors. One door was equipped with a manual latching device which would latch into the door frame</p> | K020018   | The facility installed, and tested a self-latching device onto the electrical room double door located on the 200A hall on 2/28/14 The maintenance department will test the self-latching device on a weekly basis, and document the findings on the door pm summary. (See Attachment) | 02/28/2014   |  |   |  |

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| K020029<br>SS=D    | <p>and the remaining door was designed to latch into the stationary door. Each door could not latch automatically, and independent of the other door, into the door frame. This was acknowledged by the Environmental Services Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1<br/>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Medical Records offices, used to store combustibles and measuring over 50 square feet in size, was provided with a self closing device. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Supervisor on 02/06/14 at 12:30 p.m., the service hall corridor door to the Medical Records office which contained four shelving</p> | K020029       | The facility installed a door closing device on the door leading into the medical records office on 2/26/14 The maintenance department will test the self-latching device on a weekly basis, and document the findings on the door pm summary. (See Attachment) | 02/26/2014           |

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| K020038<br>SS=E    | <p>units full of medical records and other documentation, measuring 200 square feet in size, lacked a self closing device. This was acknowledged by the Environmental Services Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1<br/>Based on observation and interview, the facility failed to ensure 1 of 10 exit discharge paths was readily accessible at all times. This deficient practice could affect 19 residents in the 400 hall in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Supervisor on 02/06/14 at 3:16 p.m., the therapy hall exit door near resident room 415 could not be opened due to a build up of ice on the sidewalk in front of the door. The Environmental Services Supervisor acknowledged and immediately sent a maintenance assistant out to begin scrapping the ice from the sidewalk.</p> | K020038       | The facility maintenance department will keep all exterior exit paths clear of obstructions, snow, or ice. The exterior exit paths will be checked daily. This will be documented on the monthly maintenance log. (See Attachment) | 03/13/2014           |

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| K020047<br>SS=E | <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Exit and directional signs are displayed with continuous illumination also served by the emergency lighting system in accordance with section 7.10. 18.2.10.1.<br/>Based on observation and interview, the facility failed to ensure 1 of 1 doors likely to be mistaken for a way of exit was identified as "No Exit". LSC 7.10.8.1 requires any door that is neither an exit or a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall be identified by a sign that reads; NO EXIT. This deficient practice could affect 3 residents and therapy staff in the 200 hall therapy room as well as other residents in the same smoke compartment.</p> <p>Findings include:</p> <p>Based on observation and interview with the Environmental Services Supervisor on 02/06/14 at 1:20 p.m., a door in the 200 hall therapy room lead outside into an enclosed courtyard and was not considered an emergency exit. There was no sign identifying the door as "NO EXIT" for emergency purposes.</p> | K020047 | The property installed a "NOT AN EXIT" sign with 3" red letters, on the door in the Royal Café dining room leading out to the courtyard, as well on the door in the 200 hall therapy room leading to the courtyard. This was an oversight during the 2012/13 construction. The maintenance department will monitor the placement of the signs and document this on the monthly maintenance log during the morning maintenance rounds. (See Attachment) | 03/13/2014 |
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| K020050<br>SS=F  | <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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. 18.7.1.2</p> <p>1. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Fire Drill Report" with the Environmental Services Supervisor on 02/06/14 at 11:45 a.m., there was no record of a third shift fire drill for the fourth quarter of 2013. Based on an interview with the Environmental Services Supervisor at the time of record review, no other documentation was available for review to verify this drill was conducted.</p> <p>3.1-19(b)<br/>3.1-51(c)</p> | K020050   | The property maintenance department modified the "facility fire Drill Report" to include location, and type of fire. The facility maintenance department also implemented a fire drill annual schedule. The fire drill schedule and report will be monitored by both the facility maintenance manager, and facility administrator. The fire drill report will be reviewed and signed on a monthly basis by the maintenance manager, and administrator. (See Attachment) | 03/13/2014   |  |   |  |

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| K020062<br>SS=E  | <p>2. Based on record review and interview, the facility failed to include the fire drill location and type of fire for 12 of the last 12 calendar months. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Fire Drill Report" with the Environmental Services Director on 02/06/14 at 11:55 a.m., the fire drill documentation did not include the location of the fire drill and the type of fire simulated. This was acknowledged by the Environmental Services Director at the time of record review.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 sprinkler heads was unobstructed in the 100 hall shower room. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested</p> | K020062   | Shambaugh and Sons sprinkler division removed the sprinkler heads in question under the canopy located at the CCU entrance, and replaced with all but two of the six head with new non corrosive sprinkler heads on 02/27/14. The additional heads | 03/13/2014   |  |   |  |

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| K020077<br>SS=E    | <p>and maintained in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice could affect 5 residents and staff in the 100 hall shower room.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Supervisor on 02/06/14 at 2:01 p.m., the spray pattern for the sprinkler head in the 100 hall shower room was obstructed by a wall which extends to the ceiling between the stool and the shower. At the time of observation, the Environmental Services Supervisor stated the wall of the enclosed shower would obstruct the sprinkler spray pattern.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Piped in medical gas systems comply with NFPA 99, Chapter 4.<br/>Based on observation and interview, the facility failed to maintain 1 of 1 piped medical gas systems. NFPA 99 Section</p> | K020077       | <p>where installed on 03/13/14 due to the material being back ordered. Shambaugh and Sons added a sprinkler head in the break room closet at other side of obstruction to ensure 100% full coverage on 2/27/14. Shambaugh and Sons added a sprinkler head in the shower room located on the 100 hall on 02/27/14. The shower room has 100% sprinkler coverage. Sprinkler head coverage and questionable corrosion will be monitored and documented by Shambaugh and Sons on a quarterly basis. The facility maintenance department will visually inspect all outdoor sprinkler heads on a quarterly basis, and document the findings on the outdoor sprinkler head pm summary. (See Attachment)</p> <p>The facility contracted LA Electric to replace the defective circuit boards in the MEDVAC master oxygen system. The work was</p> | 02/19/2014           |

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| K020147<br>SS=D  | <p>4-3.5.2.3(d) requires the responsible authority of the facility shall establish procedures to ensure that all signal warnings are promptly evaluated and that all necessary measures are taken to reestablish the proper functions of the medical gas system. This deficient practice could affect 4 residents.</p> <p>Finding include:</p> <p>Based on observation of the master panel for the piped in medical gas system with the Environmental Services Supervisor on 02/06/14 at 12:52 p.m. at the 200 hall nurses' station, there was an illuminated red light for low in Zone 2, indicated as resident rooms 227 through 230, and additionally in the information panel there was an "H" under PSI.</p> <p>Based on an interview with the Environmental Services Supervisor at the time of observation, he believed the trouble was with the board at the master alarm panel and not a problem with the system.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> |   | <p>tested and completed on 2/19/14. The maintenance department will monitor and test the oxygen panel daily. This will be documented on the monthly maintenance log. (See Attachment)</p> |  |  |   |  |

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|  | <p>Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords such as extension cord power strips were not used as a substitute for fixed wiring. 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, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a resident care area but could affect staff.</p> <p>Findings include:</p> <p>Based on an observation with the Environmental Services Supervisor on 02/06/14 at 1:48 p.m., an extension cord power strip was plugged in and providing power to another extension cord power strip which was plugged in and providing power to another extension cord power strip which was plugged in and providing power to IT equipment in the 100 hall mechanical room. The Environmental Services Supervisor acknowledged three separate power strips were plugged in and providing electricity to IT equipment in the 100 hall mechanical room.</p> <p>3.1-19(b)</p> | K020147   | The facility contacted our IT person to remove the power strips, and install a UL rated outlet strip that will accommodate the servers and be a direct plug into the outlet. This was completed on 2/26/14. The facility maintenance manager in-serviced the Kingston IT person on the code requirements for using power strips, and the no use of extension cords. When any IT work is done by the Kingston IT or other persons the maintenance manager will inspect the work done and sign off on the work order, and keep a copy on file. (See Attachment) | 02/26/2014   |  |   |  |

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