

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155542	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/21/2016
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NAME OF PROVIDER OR SUPPLIER  CLOVERLEAF OF KNIGHTSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857
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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: 09/21/16</p> <p>Facility Number: 000296 Provider Number: 155542 AIM Number: 100467820</p> <p>At this Life Safety Code survey, Cloverleaf of Knightsville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. The original facility and two additions constructed prior to March 1, 2003 were surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility with a partial basement was surveyed as two separate buildings due to the construction dates of the facility. The original facility and two additions constructed prior to March 1, 2003 were determined to be of Type V (111) construction and fully sprinklered.</p>	K 0000	This plan of correction is submitted as required by law. By submitting this plan of correction Cloverleaf Healthcare does not admit that the citations listed on the CMS 2567 exist nor does it admit to any statement, finding, facts or conclusion that forms the basis of alleged citations.	

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 0015 SS=D Bldg. 01	<p>The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and in resident rooms on the A wing. Resident rooms in the B and C wings were equipped with battery operated smoke alarms. The facility has a capacity of 102 and had a census of 80 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except, the detached laundry building.</p> <p>Quality Review completed on 09/28/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 smoke compartments was provided with a complete interior finish with a flame spread rating of Class A, Class B or Class</p>	K 0015	<p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue</p> <p><b>Maintenance has</b></p>	10/05/2016

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K 0025 SS=E Bldg. 01	<p>C for a sprinklered facility. LSC 3.3.112 defines interior finish as the exposed surfaces of walls, ceilings and floors. A.3.3.112 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient practice could affect 2 residents in room 13.</p> <p>Findings include:</p> <p>Based on observation on 09/21/16 at 12:25 p.m. during a tour of the facility with the Maintenance Supervisor, there were two, five foot long exposed wood 2" X 4"s attached to the ceiling and separating the two sprinkler heads in room 13. This was acknowledged by the Maintenance Supervisor at the time of observation, furthermore, the Maintenance Supervisor said the two, five foot long exposed wood 2" x 4"s did not have a flame spread rating.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire</p>		<p><b>removed the untreated wood 2x4's and installed metal support brackets</b></p> <p><b>Maintenance has toured building and audited building for untreated wood or objects without a flame spread rating. There were no further objects found.</b></p> <p><b>Maintenance will continue to audit quarterly all fixed or movable walls, partitions, columns, ceilings, have a flame spread rating of Class A or B.</b></p> <p><b>Administrator to monitor</b></p> <p><b>10/05/2016</b></p>		

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	<p>resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames.</p> <p>8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect over residents, staff and visitors while in the corridor and adjacent rooms near the Dining Room, Activity Room, and Physical Therapy Room.</p> <p>Findings include:</p> <p>Based on observation on 09/21/16 at 1:20 p.m. during a tour of the facility with the Maintenance Supervisor, the smoke barrier wall in the attic between the new and existing portions of the facility (between Dining Room and Activity Room) had exposed penetrations through</p>	K 0025	<p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue</p> <p><b>Maintenance Director has filled the penetrations between dining room and activity room with fire caulk.</b></p> <p><b>Maintenance Director has examine all smoke barrier walls and found all to be in compliance and no further penetrations found.</b></p> <p><b>Maintenance Director will complete monthly rounds to assure no new penetrations are found and report to administrator</b></p> <p><b>Administrator to</b></p>	10/14/2016

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K 0038 SS=E Bldg. 01	<p>the smoke barrier wall ranging in size from 1/2 inch to 3 inches around three wire bundles and a sprinkler pipe that were not properly fire stopped. Also, there was 3 inch by 5 inch open hole through the wall that was not properly sealed.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned penetrations did not ensure the smoke barrier wall was protected to maintain the smoke resistance of the smoke barrier.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure a handrail was provided for 1 of 2 exits with ramps. LSC 19.2.1 refers to Chapter 7. LSC 7.2.5.4 states handrails shall be provided along both sides of a ramp run with a rise greater than six inches. LSC 7.2.2.4.2 states ramps shall have handrails on both sides. Exception No. 3 says existing ramps shall be permitted to have a handrail on one side only. This deficient practice could affect up to 25 residents, as well as staff and visitors while exiting through the outside Activity Room exit.</p>	K 0038	<p><b>oversee compliance and assure results be completed.</b></p> <p><b>10/14/2016</b></p> <p>K038 Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue <b>Contractor for facility has installed a handrail on sidewalk/ramp coming from activity room/dining room exit to courtyard sidewalk.</b> Maintenance Director has checked all sidewalks/ramp with grade change of 1 foot. Maintenance Director will assure all sidewalks/ramps of grade</p>	10/14/2016

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K 0050 SS=F Bldg. 01	<p>Findings include:</p> <p>Based on observation on 09/21/16 at 1:00 p.m. during a tour of the facility with the Maintenance Supervisor, the exit from the Activity Room had a ten foot sidewalk/ramp which had a grade change of over one foot from top to bottom. There was no handrail on either side of the ramp. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>1. Based on record review and interview, the facility failed to ensure each documented fire drill included complete documentation of the transmission of a fire alarm signal to the monitoring</p>	K 0050	<p>change of 1 foot from top to bottom on upcoming addition will be equipped with proper hand rails Administrator to monitor</p> <p>Completed 10/14/2016</p> <p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue</p> <p><b>Maintenance Director</b></p>	10/14/2016

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	<p>company/fire department for 2 of 12 fire drills. LSC 19.7.1.2 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills on 09/21/16 at 10:30 a.m. with the Maintenance Supervisor present, fire drills performed during the third shift of the third quarter (July, August and September), and fourth quarter (October, November, and December) of 2015 did not include information that the monitoring company/fire department were called to verify the transmission of the fire alarm was received. Based on interview at the time of record review, this was acknowledged by the Maintenance Supervisor.</p> <p>3-1.19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility.</p>		<p><b>has been re educated on importance of having fire drills at different times during each shift and also to sound the alarm and assure fire monitoring company has received signal after a third shift silent alarm drill was preformed.</b></p> <p><b>Maintenance Director had third shift fire alarm on September 29th and called September 30th to assure monitoring company received signal in which they did. Maintenance Director will continue to call once a quarter after third shift alarm. Monthly Fire Drills will be set up to utilize the entire 8 hour shift</b></p> <p><b>Administrator to audit</b></p>	

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K 0056 SS=D Bldg. 01	<p>Findings include:</p> <p>Based on review of the facility's fire drills on 09/21/16 at 10:30 a.m. with the Maintenance Supervisor present, four of four, second shift (evening) fire drills were performed between 2:11 p.m. and 3:45 p.m. During an interview at the time of record review, the Maintenance Supervisor acknowledged the times the second shift fire drills were performed and agreed the times were not varied enough.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>1. Based on observation and interview, the facility failed to ensure steel armover sprinkler pipes in 1 of 5 smoke compartments were installed in accordance with the requirements of</p>	K 0056	<p><b>fire drill reports and oversee compliance.</b></p> <p><b>10/14/2016</b></p> <p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue:</p> <p><b>Contracted company</b></p>	10/14/2016	

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	<p>NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect 2 residents in room 13.</p> <p>Findings include:</p> <p>Based on observation on 09/21/16 at 12:25 p.m. during a tour of the facility with the Maintenance Supervisor, the steel sprinkler pipe armover in room 13 was over eight feet long and was unsupported.</p> <p>This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to insure 1 of 5 smoke compartments had sprinkler heads installed in accordance with NFPA 13, Section 5-1.1 and 5-6.3.4 which requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect 2 residents in room 13.</p>		<p><b>Safe Care installed support for the 8 foot plus steel sprinkler pipe armover in room 13</b></p> <p><b>Maintenance and representative toured building and found no other sprinkler pipes over 24 inches to be unsupported</b></p> <p><b>Maintenance Director will audit quarterly to assure sprinkler pipes are properly supported</b></p> <p><b>Administrator to audit fire drill reports and oversee compliance.</b></p> <p><b>10/14/2016</b></p>	

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K 0062 SS=F Bldg. 01	<p>Findings include:</p> <p>Based on observation on 09/21/16 at 12:25 p.m. during a tour of the facility with the Maintenance Supervisor, there were two sprinkler heads within 18 inches of each other in room 13. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure a full hydrostatic flush was performed on 2 of 2 automatic sprinkler piping system that was internally inspected as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping</p>	K 0062	<p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue</p> <p><b>Safe care has been instructed to begin process of starting the hydro static flushing of our sprinkler systems. This process takes approximately 3 months per Contract Company. Therefore process will not be completed until after date certain but will be in process of.</b></p> <p><b>The internal sprinkler test will be completed</b></p>	10/14/2016

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	<p>despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of sprinkler system inspection reports on 09/21/16 at 11:00 a.m. with the Maintenance Supervisor and the Administrator present, the Safe Care inspection dated 07/16/14 stated "Performed Internal Pipe Inspection found both systems to need flushed Found rust and debris in systems" The Maintenance Supervisor and the Administrator both acknowledged what the 7/16/14 Safe Care inspection report stated, however, they said someone else at Safe Care said the report was not accurate and that a flush was not necessary, however, there was no documentation available from Safe Care to confirm this. Furthermore, the Maintenance Supervisor and the Administrator stated the flush has not been performed.</p> <p>3-1.19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of over 500</p>		<p><b>every 5 years to determine obstructions in sprinkler system.</b></p> <p><b>Maintenance Director will monitor compliance of 5 year test</b></p> <p><b>Administrator to oversee compliance and assure results be completed.</b></p> <p><b>10/14/2016</b></p>	

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K 0144 SS=C Bldg. 01	<p>sprinkler heads in the facility was free of corrosion. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be free of paint and corrosion. Any sprinkler shall be replaced that is painted or corroded. This deficient practice could affect up to 37 residents, as well as staff and visitors in the northwest corridor.</p> <p>Findings include:</p> <p>Based on observation on 09/21/16 at 12:08 p.m. during a tour of the facility with the Maintenance Supervisor, the sprinkler head in the northwest hall soiled utility room was covered with green corrosion. This was acknowledged by the Maintenance Supervisor at the time of observation.</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 provide</p>	K 0144	K144 Our facility strives to provide the	10/14/2016			

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	<p>documentation the generator was load tested for 30 minutes during 12 of the past 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>This deficient practice could affect all residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the monthly</p>		<p>best care possible. Consistent with this practice we have addressed the following issue Maintenance Director has ran generator under load for a total amount of 30 minutes and cooled down for 10 minutes and generator performed properly Maintenance Director will continue to perform monthly checks of generator under this stipulation of running for total of 30 minutes, cooling down 20 minutes Maintenance Director will keep log monthly to confirm proper testing documentation. Administrator to monitor for compliance 10/14/2016</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155542		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/21/2016	
NAME OF PROVIDER OR SUPPLIER  CLOVERLEAF OF KNIGHTSVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857			
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K 0000  Bldg. 04	<p>generator load testing documentation on 09/21/16 at 11:45 a.m. with the Maintenance Supervisor present, there was documentation available a generator load test was performed monthly during the past twelve months, however, the documentation showed the generator was ran under load for only 20 minutes each month instead of the 30 minute requirement. This was confirmed by the Maintenance Supervisor at the time of record review.</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: 09/21/16</p> <p>Facility Number: 000296 Provider Number: 155542 AIM Number: 100467820</p> <p>At this Life Safety Code survey, Cloverleaf of Knightsville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from</p>	K 0000	This plan of correction is submitted as required by law. By submitting this plan of correction Cloverleaf Healthcare does not admit that the citations listed on the CMS 2567 exist nor does it admit to any statement, finding, facts or conclusion that forms the basis of alleged citations.				

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K 0025 SS=E Bldg. 04	<p>Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. The 2006 addition was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>The 2006 one story addition was determined to be of Type V (111) construction and fully sprinklered. The 2006 addition has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 102 and had a census of 80 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except, the detached laundry building.</p> <p>Quality Review completed on 09/28/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5</p>			

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	<p>Based on observation and interview, the facility failed to ensure 1 of 4 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect over residents, staff and visitors while in the corridor and adjacent rooms near the Dining Room, Activity Room, and Physical Therapy Room.</p> <p>Findings include:</p> <p>Based on observation on 09/21/16 at 1:20 p.m. during a tour of the facility with the Maintenance Supervisor, the smoke barrier wall in the attic between the new and existing portions of the facility (between Dining Room and Activity Room) had exposed penetrations through the smoke barrier wall ranging in size from 1/2 inch to 3 inches around three wire bundles and a sprinkler pipe that were not properly fire stopped. Also, there was 3 inch by 5 inch open hole through the wall that was not properly</p>	K 0025	<p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue</p> <p><b>Maintenance Director has filled the penetrations between dining room and activity room with fire caulk.</b></p> <p><b>Maintenance Director has examine all smoke barrier walls and found all to be in compliance and no further penetrations found.</b></p> <p><b>Maintenance Director will complete monthly rounds to assure no new penetrations are found and report to administrator</b></p> <p><b>Administrator to oversee compliance and assure results be completed.</b></p> <p><b>10/14/2016</b></p>	10/14/2016

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K 0050 SS=F Bldg. 04	<p>sealed. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned penetrations did not ensure the smoke barrier wall was protected to maintain the smoke resistance of the smoke barrier.</p> <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 1. Based on record review and interview, the facility failed to ensure each documented fire drill included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department for 2 of 12 fire drills. LSC 19.7.1.2 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all</p>	K 0050	<p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue</p> <p><b>Maintenance Director has been re educated on importance of having fire drills at different times during each shift and also to</b></p>	10/14/2016			

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	<p>residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills on 09/21/16 at 10:30 a.m. with the Maintenance Supervisor present, fire drills performed during the third shift of the third quarter (July, August and September), and fourth quarter (October, November, and December) of 2015 did not include information that the monitoring company/fire department were called to verify the transmission of the fire alarm was received. Based on interview at the time of record review, this was acknowledged by the Maintenance Supervisor.</p> <p>3-1.19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills on 09/21/16 at 10:30 a.m. with the Maintenance Supervisor present, four of four, second shift (evening) fire drills</p>				<p><b>sound the alarm and assure fire monitoring company has received signal after a third shift silent alarm drill was preformed.</b></p> <p><b>Maintenance Director had third shift fire alarm on September 29th and called September 30th to assure monitoring company received signal in which they did. Maintenance Director will continue to call once a quarter after third shift alarm. Monthly Fire Drills will be set up to utilize the entire 8 hour shift</b></p> <p><b>Administrator to audit fire drill reports and oversee compliance.</b></p> <p><b>10/14/2016</b></p>		

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K 0062 SS=F Bldg. 04	<p>were performed between 2:11 p.m. and 3:45 p.m. During an interview at the time of record review, the Maintenance Supervisor acknowledged the times the second shift fire drills were performed and agreed the times were not varied enough.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to ensure a full hydrostatic flush was performed on 2 of 2 automatic sprinkler piping system that was internally inspected as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for</p>	K 0062	<p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue</p> <p><b>Safe care has been instructed to begin process of starting the hydro static flushing of our sprinkler systems. This process takes approximately 3 months per Contract Company. Therefore process will not be completed until after date certain but will be in process of.</b></p> <p><b>The internal sprinkler test will be completed every 5 years to determine obstructions</b></p>	10/14/2016

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K 0144 SS=C Bldg. 04	<p>obstructions every 5 years. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of sprinkler system inspection reports on 09/21/16 at 11:00 a.m. with the Maintenance Supervisor and the Administrator present, the Safe Care inspection dated 07/16/14 stated "Performed Internal Pipe Inspection found both systems to need flushed Found rust and debris in systems" The Maintenance Supervisor and the Administrator both acknowledged what the 7/16/14 Safe Care inspection report stated, however, they said someone else at Safe Care said the report was not accurate and that a flush was not necessary, however, there was no documentation available from Safe Care to confirm this. Furthermore, the Maintenance Supervisor and the Administrator stated the flush has not been performed.</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),</p>		<p><b>in sprinkler system.</b></p> <p><b>Maintenance Director will monitor compliance of 5 year test</b></p> <p><b>Administrator to oversee compliance and assure results be completed.</b></p> <p><b>10/14/2016</b></p>	

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	<p><b>Chapter 6 (NFPA 110)</b> Based on record review and interview, the facility failed to provide documentation the generator was load tested for 30 minutes during 12 of the past 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>This deficient practice could affect all residents, as well as staff and visitors.</p>	K 0144	<p>K144 Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue Maintenance Director has ran generator under load for a total amount of 30 minutes and cooled down for 10 minutes and generator performed properly Maintenance Director will continue to perform monthly checks of generator under this stipulation of running for total of 30 minutes, cooling down 20 minutes Maintenance Director will keep log monthly to confirm proper testing documentation. Administrator to monitor for compliance 10/14/2016</p>	10/14/2016	

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	<p>Findings include:</p> <p>Based on a review of the monthly generator load testing documentation on 09/21/16 at 11:45 a.m. with the Maintenance Supervisor present, there was documentation available a generator load test was performed monthly during the past twelve months, however, the documentation showed the generator was ran under load for only 20 minutes each month instead of the 30 minute requirement. This was confirmed by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b)</p>				