

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY NORTHVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1235 W CROSS ST ANDERSON, IN 46011
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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: 12/18/14</p> <p>Facility Number: 000562 Provider Number: 155718 AIM Number: 100267150</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Community North Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and 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</p>	K010000	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	

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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K010018 SS=E	<p>operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 101 and had a census of 73 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except one detached storage building.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/29/14.</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 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS</p>			

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	<p>regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of over 75 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 20 residents, staff and visitors in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 12/18/14, the main dining room is open to the corridor and the middle entry door to the kitchen from the dining room was propped in the fully open position with a wedge. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned corridor door failed to resist the passage of smoke and provided an impediment to closing and latching.</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</p>	K010018	<p>K 018 The deficient practice was immediately corrected by removing the prop on the door. The Maintenance department completed a house-wide audit for other doors being propped and none were found. A magnetic closer that is connected to the fire alarm system will be installed on the identified door the week of 1/4/15. This is being installed to eliminate future instances of the door being propped. All kitchen staff has been informed that it is against regulations to use a prop like that on doors in our facility. The Maintenance Director will add a house-wide sweep for door props to his monthly PM activities.</p>	01/17/2015			
K010038 SS=F	<p>Based on observation and interview, the</p>	K010038	<p>K 038 The deficient practice was</p>	01/17/2015			

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	<p>facility failed to ensure the means of egress through 9 of 9 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. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 12/18/14, all nine exit doors were each marked as a facility exit to the public way, 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 the observations, the Maintenance Supervisor stated not all residents in each smoke compartment</p>		corrected by posting the four digit code at all nine exits.				

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K010048 SS=D	<p>have a clinical diagnosis requiring specialized security measures and acknowledged the four digit code was not posted at each of nine facility exits. 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>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: (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</p>	K010048	K 048 The deficient practice was corrected by adding a section on K Class fire extinguishers to the Disaster Manual. In addition the dietary staff has been instructed on the proper use of a K Class fire extinguisher by the Dietary Manager the week of 1/4/15.	01/17/2015

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K010050 SS=C	<p>kitchen staff.</p> <p>Findings include:</p> <p>Based on review of "Policies and Procedures for Safety" documentation with the Maintenance Supervisor during record review from 9:40 a.m. to 12:45 p.m. on 12/18/14, the written fire safety 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 Maintenance Supervisor during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 12/18/14, one K class fire extinguisher was located in the kitchen. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the written fire safety plan for the facility did not include kitchen 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 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</p>			

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K010053 SS=C	<p>of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" with the Maintenance Supervisor during record review from 9:40 a.m. to 12:45 p.m. on 12/18/14, second shift fire drills conducted on 02/21/14, 05/21/14 and 11/26/14 were conducted at, respectively, 3:44 p.m., 3:00 p.m. and 2:45 p.m.</p> <p>Based on interview at the time of record review, the Maintenance Supervisor acknowledged second shift fire drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p> <p>NFPA 101, 483.70(a)(7) LIFE SAFETY CODE STANDARD In an existing nursing home, not fully sprinklered, the resident sleeping rooms and</p>	K010050	<p>K 050</p> <p>The deficient practice will be corrected by having more time variability with the fire drills. The Maintenance Director will not conduct successive drills on a particular shift within two hours of the previous drill.</p>	01/17/2015

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	<p>public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. 42 CFR 483.70(a)(7)</p> <p>Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 51 of 51 resident 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 all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Smoke Detector Maintenance Log for 2013/2104" documentation with the Maintenance Supervisor during record review from 9:40 a.m. to 12:45 p.m. on 12/18/14, an itemized listing of battery operated smoke detector testing for the most recent twelve month period was not available for review. The results of testing battery operated smoke detectors in resident sleeping rooms are all grouped together and documented as being on a weekly basis. Based on observations with the Maintenance Supervisor during</p>	K010053	<p>K 053</p> <p>The deficient practice was corrected by adding an itemized check off list of every smoke detector in the facility to the preventative maintenance program. All smoke detectors will be tested monthly by the Maintenance Director.</p>	01/17/2015

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K010067 SS=F	<p>a tour of the facility from 12:45 p.m. to 3:10 p.m. on 12/18/14, battery operated smoke detectors are installed in all 51 resident sleeping rooms. Based on interview at the time of record review and of the observations, the Maintenance Supervisor acknowledged an itemized listing of battery operated smoke detector testing for the most recent twelve month period was not available for review.</p> <p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers</p>	K010067	<p>K 067</p> <p>The deficient practice was corrected by scheduling inspection and maintenance of all of the fire dampers in the facility. This work was completed on 12/30/14. A damper inspection check off form will be added to the facilities preventative maintenance program. The Maintenance Director will schedule the damper inspection every three years and document on the form that the work will be completed. The inspection report will be kept on file with the other preventative maintenance documentation. The Maintenance Director is</p>	01/17/2015

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	<p>shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor from 9:40 a.m. to 12:45 p.m. on 12/18/14, documentation of fire damper inspection and maintenance performed within the most recent four year period was not available for review. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 12/18/14, the following was noted:</p> <p>a. two fire dampers each with an affixed sticker stating a manufacture date of April 1996 were noted in the ceiling in HVAC supply vents in the corridor by the nurses station by the Dogwood Lounge.</p> <p>b. two fire dampers each with an affixed sticker stating a manufacture date of April 1996 were noted in the ceiling HVAC supply vents above the nurses station by the Rosewood Lounge.</p> <p>c. one fire damper was noted in the ceiling HVAC supply vent in the corridor by the nurses station by the Rosewood Lounge.</p>		responsible for this plan of correction.		

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K010069 SS=D	<p>d. one fire damper with and affixed sticker stating a manufacture date of June 1996 was noted in the ceiling HVAC supply vent in the Activities Office. Based on interview at the time of record review and of the observations, the Maintenance Supervisor acknowledged documentation of fire damper inspection and maintenance performed within the most recent four year period was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits</p>	K010069	<p>K 069 The deficient practice was corrected by scheduling the cleaning and inspection of the kitchen range hood and exhaust system. This was completed on 12/30/14. The range hood cleaning has been added to the facilities preventative maintenance program and the Maintenance Director will be responsible for validating that the inspection and cleaning has been completed every six months. The deficient practice regarding the hood system drip tray was corrected by adding an enclosed metal container for the grease to drain into.</p>	01/17/2015

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	<p>from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect three staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on review of Elwood Fire Equipment Company "Hood Cleaning Report" documentation dated 05/22/14 with the Maintenance Supervisor during record review from 9:40 a.m. to 12:45 p.m. on 12/18/14, documentation of semiannual kitchen exhaust systems inspection six months after 05/22/14 was not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 12/18/14, a sticker was affixed to the kitchen range hood indicating the most recent hood inspection was performed on 05/22/14. Based on interview at the time of record review and of the observation,</p>			

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	<p>the Maintenance Supervisor acknowledged documentation of semiannual kitchen exhaust systems inspection six months after 05/22/14 was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 1998 edition, Section 3-2.6 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect three staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 12/18/14, one of one designated</p>			

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K010074 SS=C	<p>locations underneath the kitchen range hood system drip tray was missing an enclosed metal container for grease to drain into. The designated location for a grease container had a one inch in diameter hole in the drip tray beneath the system filters and had affixed brackets for holding a container but no container was present. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the designated location underneath the kitchen range hood system drip tray was missing an enclosed metal container for grease to drain into.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4.</p>			

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	<p>19.7.5.3 Based on record review, observation and interview; the facility failed to ensure valences and window curtains in 7 of 7 smoke compartments were flame resistant. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor from 9:40 a.m. to 12:45 p.m. on 12/18/14, documentation of valence and window curtain flame resistant documentation was not available for review. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:45 p.m. to 3:10 p.m., window valences and curtains installed in each smoke compartment had no affixed documentation stating each valence or curtain was inherently flame retardant. Based on interview at the time of record review and of the observations, the Maintenance Supervisor stated only the window shade in the Dogwood sun porch had been treated with a flame retardant material, no other valence or curtain in the facility was known to be treated with a flame retardant material and acknowledged documentation for flame retardant material treatment and valence and window curtain flame resistant</p>	K010074	<p>K 074 The deficient practice was corrected by completing a house-wide audit for draperies, curtains, cubicle curtains, and other loosely hanging fabrics that do not have attached documentation or documentation of having been treated with flame retardant material. All items out of compliance have been treated or removed from the facility by 1/10/15. This includes the items specifically identified in the survey report. No new draperies, curtains, cubicle curtains, and other loosely hanging fabrics will be brought into the facility without documentation of having been treated with flame retardant material. The Maintenance Director and Housekeeping Supervisor are responsible for this plan of correction.</p>	01/17/2015			

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K010144 SS=C	<p>documentation was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 4 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators 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</p>	K010144	<p>K 144</p> <p>The deficient practice was corrected by having the generator vendor out to instruct the Maintenance Director on how to increase the load during weekly testing so that we exceed the 30% standard. This was completed the week of 1/4/15. The Maintenance Director is responsible for completing and documenting the generator tests on a weekly basis. We have also requested a letter from the natural gas company stating reasonable reliability of fuel supply. We fully expect to have the letter in hand by 1/17/15.</p>	01/17/2015

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	<p>exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Weekly Generator Test Log: Percentage of Load" documentation with the Maintenance Supervisor during record review from 9:40 a.m. to 12:45 p.m. on 12/18/14, documentation of monthly load testing for July, October, November and December 2014 each recorded the monthly load test as less than 30% of the Emergency Power Supply (EPS) nameplate rating. In addition, each of the aforementioned monthly load tests did not document the test was under operating temperature conditions or at loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Based on interview at the time of record review, the Maintenance Supervisor</p>			

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	<p>acknowledged documentation for the aforementioned monthly load tests were not conducted under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure documentation of the reliability for the off site fuel source for 1 of 1 emergency generators was available for review. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <ul style="list-style-type: none"> a) Liquid Petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas <p>Exception: For Level 1 installations in locations where the probability of interruption of offsite fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility</p>			

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	<p>unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all clients, staff and visitors. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:</p> <ol style="list-style-type: none"> 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical person from the natural gas provider. <p>This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor from 9:40 a.m. to 12:45 p.m. on 12/18/14,</p>			

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K010154 SS=C	<p>documentation of reliability from the off site natural gas supplier for the emergency generator was not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 12/18/14, the facility emergency generator is fueled by natural gas only. Based on interview at the time of record review and observation, the Maintenance Supervisor stated the fuel source for the emergency generator was natural gas and acknowledged documentation of reliability from the natural gas provider was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period in order to protect 73 of 73</p>	K010154	<p>K 154 The deficient practice was corrected by finding the Community Northview Fire Watch Procedure document. The document was copied along with the other vital Disaster Preparedness documents and placed into a manual at the front</p>	01/17/2015

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	<p>residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Policy Regarding Loss of Sprinkler System" documentation with the Maintenance Supervisor and Director of Quality Assurance during record review from 9:40 a.m. to 12:45 p.m. on 12/18/14, the fire watch policy stated a fire watch would be initiated "in the event the sprinkler system is out of service for more than four hours in a thirty four hour period." In addition, the Director of Quality Assurance provided a second fire watch policy for review for Summit Convalescent Center and Parkview health care facilities which was not specific to Community Northview Care Center. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the written fire watch policy did not include initiation of a facility fire watch in the event the</p>		<p>office, each nurses' station, and the kitchen. The Administrator is responsible for this plan of correction.</p>	

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K010155 SS=C	<p>automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 in order to protect 73 of 73 residents. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor and Director of Quality Assurance during record review from 9:40 a.m. to 12:45 p.m. on</p>	K010155	<p>K 155 The deficient practice was corrected by finding the Community Northview Fire Watch Procedure document. The document was copied along with the other vital Disaster Preparedness documents and placed into a manual at the front office, each nurses' station, and the kitchen. The Administrator is responsible for this plan of correction.</p>	01/17/2015			

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	<p>12/18/14, a written fire watch policy in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period was not available for review. In addition, the Director of Quality Assurance provided a fire watch policy for review for Summit Convalescent Center and Parkview health care facilities which was not specific to Community Northview Care Center. Based on interview at the time of record review, the Maintenance Supervisor acknowledged a written fire watch policy in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period was not available for review.</p> <p>3.1-19(b)</p>				