

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155294	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/10/2014
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NAME OF PROVIDER OR SUPPLIER  FORUM AT THE CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240
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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: 02/10/14</p> <p>Facility Number: 000191 Provider Number: 155294 AIM Number: NA</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Forum at the Crossing 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, in all areas open to the corridor, in residents rooms 421 through</p>	K010000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the veracity of the alleged or conclusion set forth in the "Statement of Deficiencies."The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.	

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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K010022 SS=E	<p>428 and in resident rooms 614 through 630. The facility has battery operated smoke detectors in all other resident sleeping rooms. The facility has a capacity of 74 and had a census of 59 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</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 Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 1 of 1 Memory Care Activity Room 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 nor a way of</p>	K010022	K 022 In response to cited findings, the following actions will be taken: NFPA 101 LIFE SAFETY CODE STANDARD LSC 7.10.1.4 Doors likely to be mistaken for Exits shall be identified as "No Exit." A) The Illuminated sign identifying the	03/12/2014

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	<p>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 10 residents, staff and visitors in the Memory Care Activities Room.</p> <p>Findings include:</p> <p>Based on observation with the visiting Maintenance Director and the Maintenance Assistant during a tour of the facility from 11:40 a.m. to 2:15 p.m. on 02/10/14, the Memory Care Activities Room door leading to the outside of the facility led to the courtyard which did not lead to the public way and was not provided with a sign which identified the door as not an exit. The aforementioned door to the courtyard was provided with an exit sign but the Maintenance Assistant stated the Memory Care Activities Room door to the courtyard did not lead to the public way and is not an exit for the facility. Based on interview at the time of observation, the Maintenance Assistant stated the door to the outside of the facility did not lead to the public way and acknowledged the aforementioned door was not provided with a NO Exit sign.</p> <p>3.1-19(b)</p>		<p>exterior activity room door will be removed. A "No Exit" sign will be placed on the door. B) All residents of the Memory Care Unit and visiting residents from the SNF unit are potentially affected by assuming all exterior doors are true exits. C) The Maintenance Director and/or designee will keep a floor plan showing exits and non-exit exterior doors with monthly fire protection monitoring. Proper signage will be assessed at the same time fire extinguishers are checked on a monthly basis. Any incorrect signage will be removed immediately and corrected. D) The HFA will include observations of proper exit labeling on his weekly environmental rounds. He will ensure the Maintenance Director keeps signage accurate and up-to-date. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of compliance with proposed actions: March 12, 2014</p>		

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 14 residents, staff and visitors in the 400 Hall.</p> <p>Findings include:</p> <p>Based on observations with the visiting Maintenance Director and the Maintenance Assistant during a tour of the facility from 11:40 a.m. to 2:15 p.m. on 02/10/14, the following was noted:</p> <p>a. a one inch in diameter hole in the ceiling smoke barrier of the 400 Hall Storage Room by Room 410 for the</p>	K010025	<p>K 025 In response to cited findings, the following actions will be taken: NFPA 101 LIFE SAFETY CODE STANDARD LSC 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Smoke barriers in ceilings shall be maintained intact so as to prevent passage of smoke between compartments.</p> <p>A) These openings will be properly filled with approved materials to preclude passage of smoke:</p> <ul style="list-style-type: none"> <li>· 1" ceiling hole in the #400 storage room.</li> <li>· 1" x .5" hole next to a sprinkler head in the #400 unit.</li> <li>· 2.5" diameter open ended conduit and .5" open ended copper pipe through the smoke barrier by room #601.</li> <li>· 8 x 5" rectangular hole for passage of 4" electrical conduit by the Medical Records</li> </ul>	03/12/2014
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	<p>passage of one telephone cable which exposed the attic above.</p> <p>b. a one inch long by half inch wide hole in the ceiling next to a sprinkler head escutcheon which exposed the attic above.</p> <p>Based on interview at the time of the observations, the visiting Maintenance Director and the Maintenance Assistant acknowledged the aforementioned openings did not provide at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure openings through 2 of 17 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. This deficient practice could affect 30 residents, staff and visitors in the 600 Hall.</p> <p>Findings include:</p> <p>Based on observations with the visiting Maintenance Director and the Maintenance Assistant during a tour of the facility from 11:40 a.m. to 2:15 p.m. on 02/10/14, the following was noted:</p> <p>a. a two inch in diameter open ended conduit, a one half inch open ended copper pipe and a hole for the passage of</p>		<p>Office. B) All residents of areas where smoke barriers are not fully intact have the potential to be affected by incomplete barriers.</p> <p>C) The Maintenance Director and/or his designee will conduct a full inspection of the physical plant to include all penetrations of smoke barriers. All openings without sufficient closure will be corrected with appropriate materials to preclude smoke penetration. Visual inspections of smoke barriers and proper sealing will be conducted with monthly fire extinguisher checks are performed. Any improper penetrations will be corrected within 48 hours of identification.</p> <p>D) The HFA will include observations of smoke barrier maintenance on his weekly environmental rounds for the next sixty (60) days. Following that he will review records on a monthly basis. He will ensure the Maintenance Director addresses any related findings. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of compliance with proposed actions: March 12, 2014</p>				

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K010038 SS=E	<p>two telephone cables through the smoke barrier wall above the ceiling by the corridor door set by Room 601.</p> <p>b. an eight inch by five inch rectangular hole in the smoke barrier wall above the ceiling by the corridor door set by the Medical Records Office for the passage of a four inch in diameter electrical conduit.</p> <p>Based on interview at the time of the observation, the visiting Maintenance Director and the Maintenance Assistant acknowledged the aforementioned openings in the smoke barrier walls did not provide at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 4 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed</p>	K010038	K 038 In response to cited findings, the following actions will be taken: NFPA 101 LIFE SAFETY CODE STANDARD LSC 7.1. 19.2.1, 7.2.1.6.1 Exit access shall be readily accessible at all times. A) The Illuminated sign identifying the exterior Therapy Patio door will be removed. A	03/12/2014	

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	egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS		"No Exit" sign will be applied in order to direct residents using the therapy gym to the designated Exit. #500 Exit delayed release device will be adjusted for proper functionality by Stanley certified technicians. B) All residents using the Therapy Gym and/or in urgent need of exiting the #500 unit could potentially be affected by assuming exterior doors are exits and/or by expecting locks to release when sufficient pressure is applied. C) The Maintenance Director and/or designee will keep a floor plan showing exits and non-exit exterior doors with monthly fire protection monitoring. Proper signage will be assessed at the same time fire extinguishers are checked on a monthly basis. Any incorrect signage will be removed immediately and corrected. If necessary, outside contractors (Stanley Security) will be employed to correct the exit hardware for proper release upon application of pressure for the prescribed time. Appropriate signage will continue to be maintained at the location. Once revisions are employed, the Maintenance Director and/or designee will test doors on a monthly basis when fire extinguishers are checked. If exits are found to operate improperly, they will be adjusted by facility personnel and/or outside contractors as indicated. D) The HFA will include	

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	<p>This deficient practice could affect 20 residents, staff and visitors if needing to exit the facility from the 500 Hall.</p> <p>Findings include:</p> <p>Based on observation with the visiting Maintenance Director and the Maintenance Assistant during a tour of the facility from 11:40 a.m. to 2:15 p.m. on 02/10/14, the set of exit doors from the 500 Hall to the exterior of the building were marked as a facility exit, are equipped with a delayed egress lock and provided with signage stating the door could be opened in 30 seconds by pushing on the door release device but the exit door did not release when the door was pushed with the application of force for 30 seconds three separate times. Based on interview at the time of observation, the visiting Maintenance Director and the Maintenance Assistant stated the aforementioned exit doors are a facility exit, the exit doors are equipped with a delayed egress lock and acknowledged the exit doors did not release when the door was pushed with the application of force for 30 seconds three separate times.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview,</p>		<p>observations of proper exit labeling on his weekly environmental rounds. He will ensure the Maintenance Director keeps signage accurate and up-to-date. Assigned staff members who fail to maintain compliance will be reprimanded. HFA will check delayed lock release functionality on a weekly basis for the next sixty (60) days, then monthly to ensure ongoing compliance. Assigned staff members who fail to maintain compliance will be reprimanded.</p> <p>E) Date of compliance with proposed actions: March 12, 2014</p>				

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	<p>the facility failed to ensure exit access was arranged so 1 of 8 exits were readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. In addition to providing the required width to allow all occupants safe access to a public way, such access also needs to meet the requirements with respect to maintaining the means of egress free of obstructions that would prevent its use, such as snow and the need for its removal in some climates or soft ground during heavy periods of rain. This deficient practice could affect 10 residents, staff and visitors using the Therapy Center exit to the patio.</p> <p>Findings include:</p> <p>Based on observation with the visiting Maintenance Director and the Maintenance Assistant during a tour of the facility from 11:40 a.m. to 2:15 p.m. on 02/10/14, the Therapy Center exit to the patio is marked with an exit sign as a facility exit but the hard surface of the patio does not lead to or extend to the</p>						

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K010046 SS=E	<p>public way. In addition, the exit discharge to the patio was snow covered and impassible. An unpaved ten foot in length section of grass separates the patio from the public way and was also covered with snow and impassible. Based on interview at the time of observation, the visiting Maintenance Director and the Maintenance Assistant acknowledged the Therapy Center exit to the patio is marked as a facility exit but does not lead to or extend to the public way and was snow covered and impassible.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 4 of 4 battery powered lights during the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test</p>	K010046	K 046 In response to cited findings, the following actions will be taken: NFPA 101 LIFE SAFETY CODE STANDARD LSC 19.2.9.1 Battery-operated emergency lights will be tested at least 30 seconds every 30 days. At least annually, lights will be tested for 90 minutes to assure proper functionality. A) All four (4) battery-operated lights will be listed on the monthly testing	03/12/2014			

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	<p>to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect 20 residents, staff and visitors if needing to exit the facility from the 500 Hall.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Light Log" and "TELS: Logbook" documentation for the twelve month period of February 2013 through January 2014 with the visiting Maintenance Director and the Maintenance Assistant during record review from 8:50 a.m. to 11:40 a.m. on 02/10/14, the following was noted:</p> <p>a. documentation of functional testing for at least 30 seconds for 3 of 4 battery operated emergency lights located in the Therapy Center and at the 500 Hall exit was not available for review for January 2014.</p> <p>b. documentation of functional testing for at least 30 seconds for 1 of 4 battery operated emergency lights located in the Maintenance Room/Fire Pump Location</p>		<p>schedule to include at least 30-seconds of operation. One 90-minute test will be conducted prior to the March 12, 2014 and weak batteries will be identified and replaced. Following this exercise, batteries will be included on the TELS schedule for annual testing to be completed on or before the anniversary date of the 2014 test. B) Residents in areas served by battery-powered emergency lighting could be affected by failure of equipment to provide illumination. C) The Maintenance Director and/or his designee will inspect battery-operated lighting on a monthly basis and document via the TELS system or other preventive maintenance schedules. Proper functionality of battery-operated lighting will be assessed at the same time fire extinguishers are checked on a monthly basis. Any insufficiently-powered batteries found will be removed immediately and replaced. D) HFA will check battery-operated light functionality on a weekly basis for the next sixty (60) days, then monthly to ensure ongoing compliance. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of compliance with proposed actions: March 12, 2014</p>		

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	<p>for the twelve month period of February 2013 through January 2014 was not available for review.</p> <p>c. documentation of an annual test for 4 of 4 battery powered emergency lights for at least a 1 ½ hour duration for the most recent twelve month period was not available for review.</p> <p>Documentation for the June 4, 2013 test stated "90 seconds" as the result for three battery operated emergency lights tested in the aforementioned "Battery Operated Light Log".</p> <p>d. the battery operated emergency light located in the Maintenance Room/Fire Pump location was not included in the list of battery operated emergency light locations tested in the "Battery Operated Light Log." The aforementioned log listed two Therapy Center lights and one light at the 500 Hall exit as the list of all battery operated emergency lights in the facility.</p> <p>Based on observations with the visiting Maintenance Director and the Maintenance Assistant during a tour of the facility from 11:40 a.m. to 2:15 p.m. on 02/10/14, two battery operated emergency lights were located in the Therapy Center, one battery operated emergency light was located at the 500 Hall exit and one battery operated emergency light was located in the Maintenance Room/Fire Pump Location.</p>						

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K010062 SS=C	<p>Each of the aforementioned lights operated when their respective test button was pushed except for the Maintenance Room/Fire Pump Location light which failed to operate. Based on interview at the time of record review and of the observations, the visiting Maintenance Director acknowledged four battery operated emergency lights were located in the facility, documentation of an annual ninety minute test and complete monthly functional testing documentation for the most recent twelve month period for each of the aforementioned four battery operated emergency lights was not available for review.</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 Based on record review, observation and interview; the facility failed to document weekly fire pump inspection, testing and maintenance for 51 of 52 weeks.</p>	K010062	K 062 In response to cited findings, the following actions will be taken: NFPA 101 LIFE SAFETY CODE STANDARD LSC 19.7.6, 4.6.12, NFPA 13,	03/12/2014			

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	<p>Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition. NFPA 25, Chapter 5-1.1 provides the minimum requirements for the routine inspection, testing, and maintenance of fire pump assemblies. Table 5-1.1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Chapter 5-3.2.1 requires a weekly test of electric motor-driven pump assemblies shall be conducted without flowing water. This test shall be conducted by starting the pump automatically. The pump shall run a minimum of 10 minutes.</p> <p>Exception: A valve installed to open as a safety feature shall be permitted to discharge water. 5-3.2.2.1. says the automatic weekly test timer shall be permitted to be substituted for the starting procedure. The pertinent visual observations specified in Chapters 5-2.2.1, through Chapter 5-2.2.3 shall be performed weekly. Chapter 1-8 states records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility.</p>		<p>MFPA 25 9.7.5 Automatic sprinkler systems are continuously maintained in reliable operating condition with periodic tests/inspections. The fire pump associated with this system shall be tested on a weekly basis. A) The fire pump will be listed on the weekly testing schedule to include at least 10 minutes of operation. This weekly test will be included with the TELS schedule. B) All residents of the facility have the potential to be affected by an improperly functioning fire pump and/or failure of the equipment. C) The Maintenance Director and/or his designee will inspect fire pump on a weekly basis and document via the TELS system or other preventive maintenance schedules. Proper functionality of the fire pump will be assessed at the same time other required weekly inspections are done. Any negative findings will be addressed immediately by facility personnel and/or appropriate contractors. D) The HFA will include observations of fire pump inspection documentation weekly with his environmental rounds for the next sixty (60) days. Following that he will review records on a monthly basis. He will ensure the Maintenance Director keeps the pump in operational order. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of compliance with proposed</p>	

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	<p>Findings include:</p> <p>Based on review of Koorsen Fire &amp; Security "Report of Inspection/Test Annual Fire Pump" documentation dated 05/07/13 during record review with the visiting Maintenance Director and the Maintenance Assistant from 8:50 a.m. to 11:40 a.m. on 02/10/14, only an annual test, inspection and maintenance of electric motor-driven pump assemblies was conducted and documented during the most recent twelve month period. Documentation of weekly fire pump inspection, testing and maintenance for 51 of 52 weeks of the most recent twelve month period was not available for review. Based on observation with the visiting Maintenance Director and the Maintenance Assistant during a tour of the facility from 11:40 a.m. to 2:15 p.m. on 02/10/14, a fire pump for the facility's sprinkler system was located in the Maintenance Room/Fire Pump Location. Based on interview at the time of record review and observation, the visiting Maintenance Director and the Maintenance Assistant stated they were unaware weekly fire pump inspection, testing and maintenance was required and acknowledged documentation of weekly fire pump inspection, testing and maintenance for</p>		actions: March 12, 2014				

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K010064 SS=E	<p>51 of 52 weeks for the most recent twelve month period was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of 13 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect 30 residents, staff and visitors in the Main</p>	K010064	<p>K 064 In response to cited findings, the following actions will be taken: NFPA 101 LIFE SAFETY CODE STANDARD LSC 9.7.4.1 Fire extinguishers are inspected on a monthly basis in the health care facility. A) Documentation of one fire extinguisher inspections will be recorded on both affixed tags and via a list to affirm monthly checks. B) All residents in areas where fire extinguisher inspections are not documented could be affected if malfunctions of equipment occur. C) The Maintenance Director will keep a floor plan showing locations of all fire extinguishers along with space for recording of inspections as a part of the monthly preventative maintenance program. Records will be kept via TELS and/or ancillary systems. Maintenance Director and/or his designee will perform monthly inspections and provide dual</p>	03/12/2014	

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	<p>Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the visiting Maintenance Director and the Maintenance Assistant during a tour of the facility from 11:40 a.m. to 2:15 p.m. on 02/10/14, the annual maintenance tag attached to the portable fire extinguisher located in the Main Dining Room indicated a monthly inspection for December 2013 was not documented. Based on interview at the time of observation, the visiting Maintenance Director and the Maintenance Assistant stated no other monthly fire extinguisher inspection documentation was available for review and acknowledged a monthly inspection for the aforementioned portable fire extinguisher was not documented for December 2013.</p> <p>3.1-19(b)</p>		<p>documentation so back-up records are in order. D) The HFA will include observations of both fire extinguisher tags and summary forms with his weekly environmental rounds no less than once monthly. He will ensure the Maintenance Director keeps accurate and up-to-date reports of inspections. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of compliance with proposed actions: March 12, 2014</p>		

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K010072 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure 1 of 2 means of egress from the Therapy Center was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 10 residents, staff and visitors using the Therapy Center exit to the patio.</p> <p>Findings include:</p> <p>Based on observation with the visiting Maintenance Director and the Maintenance Assistant during a tour of the facility from 11:40 a.m. to 2:15 p.m. on 02/10/14, the Therapy Center exit to the patio was marked with an exit sign as a facility exit but the patio was completely obstructed with snow which had not been cleared and was impassible. Based on interview at the time of observation, the visiting Maintenance Director and the Maintenance Assistant acknowledged the Therapy Center exit to the patio was</p>	K010072	<p>K 072 In response to cited findings, the following actions will be taken: NFPA 101 LIFE SAFETY CODE STANDARD LSC 7.1.10 A) The Illuminated sign identifying the Therapy Gym Patio door will be removed. A "No Exit" sign will be placed on the door. Any area marked as "Exit" did and will have clear access via snow removal or other necessary action to ensure proper egress. B) Residents using the Therapy Gym who try to exit via a non-designated (but marked) door could be affected. The Exit sign will be removed from this door and replaced with a "No Exit" sign. C) The Maintenance Director and/or his designee will keep a floor plan showing exits and non-exit exterior doors with monthly fire protection monitoring. Proper signage will be assessed at the same time fire extinguishers are checked on a monthly basis. Any incorrect signage will be removed immediately and corrected. D) The HFA will include observations of proper exit labeling on his weekly environmental rounds. He will ensure the Maintenance</p>	03/12/2014			

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K010130 SS=E	<p>marked with an exit sign as a facility exit but the patio was completely obstructed with snow which had not been cleared and was impassable.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation, and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 49 of 74 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 49 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Smoke Detector Inspection" documentation and "TELS: Logbook" documentation for the twelve month period of February 2013 through January 2014 with the visiting</p>	K010130	<p>Director keeps signage accurate and up-to-date. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of compliance with proposed actions: March 12, 2014</p> <p>K 130 In response to cited findings, the following actions will be taken: NFPA 101 MISCELLANEOUS Battery-operated smoke detectors are inspected on a monthly basis. A) Battery-operated smoke detectors are listed on the monthly testing schedule. Battery checks are included on the TELS schedule. This omission was an oversight secondary to personnel changes. B) Residents in areas served by battery-powered smoke detectors could be affected by failure of equipment. C) The Maintenance Director and/or his designee will continue to inspect battery-operated smoke detectors on a monthly basis and document via the TELS system or other preventive maintenance schedules. Any</p>	03/12/2014	

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K010144 SS=F	<p>Maintenance Director and the Maintenance Assistant during record review from 8:50 a.m. to 11:40 a.m. on 02/10/14, documentation of the results of monthly battery operated smoke detector testing for January 2014 was not available for review. Based on interview at the time of record review, the visiting Maintenance Director and the Maintenance Assistant acknowledged documentation of the results of monthly battery operated smoke detector testing for January 2014 was not available for review. Based on observations with the visiting Maintenance Director and the Maintenance Assistant during a tour of the facility from 11:40 a.m. to 2:15 p.m. on 02/10/14, battery operated smoke detectors were observed installed in 49 of 74 resident sleeping rooms in the facility.</p> <p>3.1-19(a)</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>insufficiently-powered batteries found will be removed immediately and replaced. D) HFA will check battery-operated smoke detector functionality on a weekly basis for the next sixty (60) days, then monthly to ensure ongoing compliance. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of compliance with proposed actions: March 12, 2014</p>		

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	<p>Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 12 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 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. 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</p>	K010144	<p>K 144 In response to cited findings, the following actions will be taken: NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes/month.</p> <p>A) Generators will be placed under a load test monthly under operating temperature conditions or loading that maintains exhaust gas temperatures as recommended by the manufacturer. B) All residents of the facility could be affected by non-operational emergency power generators. C) The Maintenance Director will revise monthly inspections to include a 30-minute run time and load test under operating temperature conditions or loading that maintains exhaust gas temperatures as recommended by the manufacturer. He and/or a designee will conduct testing and document it as indicated. Weekly testing of systems will continue, but forms will be revised to include these salient details. D) The HFA will include observations generator testing and documentation on his weekly environmental rounds on a weekly basis for the next sixty (60) days, then monthly to ensure ongoing compliance. He will ensure the Maintenance Director keeps accurate and up-to-date records. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of</p>	03/12/2014

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	<p>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 "TELS: Logbook Documentation" during record review with the visiting Maintenance Director and the Maintenance Assistant from 8:50 a.m. to 11:40 a.m. on 02/10/14, documentation for the monthly load tests conducted during the twelve month period of 02/09/13 through 01/04/14 stated 20 minutes as the load run time. The aforementioned monthly load test documentation did not indicate if the emergency generator ran under operating temperature conditions or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Based on interview at the time of record review, the visiting Maintenance Director acknowledged documentation for the monthly load tests conducted during the twelve month period of 02/09/13 through 01/04/14 did not indicate the emergency generator ran for a minimum of 30 minutes under operating temperature conditions, at not less than 30% of the EPS nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p>		compliance with proposed actions: March 12, 2014		

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K010147 SS=A	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect five staff and visitors in the vicinity of the Director of Engineering Office.</p> <p>Findings include:</p> <p>Based on observation with the visiting Maintenance Director and the Maintenance Assistant during a tour of the facility from 11:40 a.m. to 2:15 p.m. on 02/10/14, a refrigerator was plugged into a power strip in the Director of Engineering Office. Based on interview at the time of observation, the visiting Maintenance Director acknowledged a</p>			K010147	<p>K 147 In response to cited findings, the following actions will be taken: NFPA 101 LIFE SAFETY CODE STANDARD Flexible cords and cables are not used as substitutes for fixed wiring of a structure. A) The power strip was removed from the refrigerator in the cited office to allow direct use of a power outlet. B) Residents in the vicinity of the office could be affected by malfunctions created by improper electrical connections. C) The Maintenance Director and/or designee will inspect all offices and utility areas to ensure flexible cords, cables and power strips are not used as a substitute for fixed wiring. Any such findings will be corrected immediately by removing cords and/or related appliances until direct use of power outlets are facilitated. Such inspections will be added to monthly checks related to fire safety. D) The HFA will include observations of proper electrical</p>		03/12/2014

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	power strip was in use as a substitute for fixed wiring at the aforementioned location.  3.1-19(b)		connections on environmental rounds on a weekly basis for the next sixty (60) days, then monthly to ensure ongoing compliance. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of compliance with proposed actions: March 12, 2014	