

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155745	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/15/2016
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NAME OF PROVIDER OR SUPPLIER HOLY CROSS VILLAGE AT NOTRE DAME INC	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 303 NOTRE DAME, IN 46556
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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: 08/15/16</p> <p>Facility Number: 002668 Provider Number: 155745 AIM Number: 200325990</p> <p>At this Life Safety Code survey, Holy Cross Village at Notre Dame Inc. 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 with a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The original building built in 1964 with the Dujarie Wing added in 1980, the Murphy Wing in 1985 and the Quinn Wing, which is a noncertified comprehensive care unit, in 2007. The</p>	K 0000	<p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p>	

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 0022 SS=E Bldg. 01	<p>facility has a fire alarm system with smoke detection on all levels including in the corridors, in spaces open to the corridors and hard wired smoke detectors in resident sleeping rooms. The facility has a capacity of 39 and had a census of 32 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas which provide facility services are sprinklered.</p> <p>Quality Review completed on 08/19/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1</p> <p>Based on observation, the facility failed to ensure 1 of 1 Schwartz and Memory Care discharge paths was marked with directional indicators to make the direction of travel to reach the public way obvious. LSC 7.10.1.2 requires exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of</p>	K 0022	<p>The discharge path sign was changed to include markings to indicate directional information to travel to the public way The signs will be added to the Preventive Maintenance Plan to assure sign is in place quarterly and the results reported back to the CQI meeting for the next six months The Plant Operations Director is responsible to monitor this change</p>	08/24/2016

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K 0025 SS=F Bldg. 01	<p>exit access. LSC 7.10.2 requires a sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. This deficient practice could affect up to 30 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 on 08/15/16 at 11:43 a.m., the Schwartz and Memory care wings used the same exit discharge path. Neither exit discharges direct occupants to a public way. If an occupant were to exit left, the path would lead to a gated courtyard with the latch on the opposite side. Based on an interview at the time of observation, the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 acknowledged the aforementioned condition.</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 resistance rating and constructed in accordance with 8.3. Smoke barriers shall</p>			

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	<p>be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 1 of 1 smoke barrier walls were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 on 08/15/16 between 10:11 a.m. and 10:18 a.m., the following ceiling penetrations were discovered:</p> <ul style="list-style-type: none"> a) a three quarter inch penetration near the Front Entrance b) a one inch penetration around a pipe in the Electrical Room c) a three inch penetration in the Basement Storage Room <p>Based on interview at the time of each observation, the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 acknowledged and provided the measurements for each</p>	K 0025	<p>All unsealed penetrations will be repaired An inspection of Dujarie smoke barriers walls will be performed and a report will be generated to be reviewed by the CQI committee for the next four quarters</p> <p>Any further penetrations will be fixed as found</p> <p>The Plant Operations Director is responsible is the completion of this plan</p>	08/31/2016

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K 0029 SS=D Bldg. 01	<p>unsealed penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Housekeeping Storage room greater than 50 square feet, a hazardous area, would self-close and positively latch into the frame. This deficient practice could affect staff and up to 10 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 on 08/15/16 at 12:14 p.m., the Housekeeping Storage room contained over fifty cardboard boxes of housekeeping supplies and other miscellaneous storage. The corridor door</p>	K 0029	<p>A door closer has been installed on the Housekeeping door The closer on the kitchen door has been scheduled to be completed and installed on August 29 The doors have been added to the Preventive Maintenance plan sheet to be inspected on a monthly basis and results reported to the CQI committee for the next 12 months The Director of Plant Operations will be responsible for the completion of this plan</p>	09/08/2016

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K 0045 SS=E	<p>did not have a self-closing device installed. Based on interview at the time of observation, the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 fuel fired Kitchen, a hazardous area, would positively latch into the frame. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 on 08/15/16 at 12:20 p.m., the Kitchen door failed to latch when tested. Based on interview at the time of observation, the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>			

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Bldg. 01	<p>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8</p> <p>Based on observation and interview, the facility failed to ensure the lighting for 1 of 1 Memory Care East means of egress were arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect staff and up to 12 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 on 08/15/16 at 11:03 a.m., the Memory Care East exit discharge had only one bulb outside. Based on interview at the time of observation, the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0045	A secondary light will be installed for the Memory Care East egress door by September 9, 2016 The lights for the egress doors will be placed on the Preventative maintenance weekly list to assure all these lights are functioning properly This list will be reviewed by the CQI committee for the next 12 months The Director of Plant Operations will be responsible for the correction of this deficiency	09/09/2016
K 0048 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of</p>			

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	<p>all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>1. Based on record review and interview, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <p>(1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire</p> <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a record review with the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 on 08/15/16 at 10:56 a.m., the facility had a written fire policy that horizontal evacuation would be performed by evacuating the smoke compartment. However, there were corridor doors that were not complete smoke or fire barriers which</p>	K 0048	<p>A new policy (attachment #1) has been written and approved and all staff have been educated as to the correct procedure (see attachment #2)</p> <p>The Director of Plant Operations will be responsible for the correction of this deficiency</p>	09/01/2016

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	<p>could cause staff to evacuate residents to a different part of the same smoke compartment and not to an adjacent compartment in the event of a fire. Based on observation, the set of doors separating the Memory Care area was not a complete barrier. Based on interview at the time of observation, the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 acknowledged and confirmed the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to provide a written plan that addressed relocation of wheeled equipment during an emergency. NFPA 101 19.2.3.4(4)(b) requires health care occupancies have a safety plan and training program. This deficient practice could affect staff and at least 10 residents.</p> <p>Findings include:</p> <p>Based on a record review with the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 on 08/15/16, the facility had a written fire policy. The policy did not include response to items stored in the corridor. Based on</p>			

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K 0051 SS=E Bldg. 01	<p>observation at 11:46 a.m., a wheeled lift was stored in the corridor near resident room 119. Based on interview at the time of observation, the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6</p>			

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	<p>Based on observation and interview, the facility failed to ensure 1 of 1 smoke detector in the Memory Care Nurses' Station Medication room, 1 of 1 Swartz Soiled Linen, and 1 of 1 Dujarie Nurses' Station Medication room was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 on 08/15/16 between 10:51 a.m. and 11:47 a.m.,</p> <p>a) the Memory Care Nurses' Station Medication room had a smoke detector located eighteen inches away from an HVAC vent.</p> <p>b) the Swartz Soiled Linen room had a smoke detector located twelve inches away from an HVAC vent.</p> <p>c) the Dujarie Nurses' Station Medication room had a smoke detector located twelve inches away from an HVAC vent.</p> <p>Based on interview at the time of observation, the Director of Plant Operations, the Plant Operations</p>	K 0051	The smoke detectors will be adjusted to comply with this rule A visual inspection will be conducted of the entire building to assure we are in compliance on this rule A report will be completed and report to the CQI committee The Director of Plant Operations will be responsible for the correction of this deficiency	09/01/2016

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K 0064 SS=F Bldg. 01	<p>Manager, and the Maintenance Technician #1 acknowledged the aforementioned conditions and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguisher near resident room 133 and 1 of 1 Employee Entrance fire extinguisher pressure gauge readings was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations, the Plant Operations</p>	K 0064	<p>The Fire extinguishers have been replaced All extinguishers in the building will be inspected to assure they are in acceptable range</p> <p>Preventative Maintenance checks will be performed on a monthly basis to assure all extinguishers are within acceptable range</p> <p>The Director of Plant Operations will be responsible for the correction of this deficiency</p>	08/31/2016

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K 0073 SS=E Bldg. 01	<p>Manager, and the Maintenance Technician #1 on 08/15/16 at 11:36 a.m. then again at 12:24 p.m., the gauge on the portable fire extinguisher located near resident room 133 indicated the extinguisher was undercharged. Then again, the Employee Entrance fire extinguisher gauge indicated the extinguisher was undercharged. Based on interview at the time of observation, the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4</p> <p>Based on observation, the facility failed to ensure 1 of 1 facility chapels remains free of combustible decorations. This deficient practice affects staff, visitors, and at least 20 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations, the Plant Operations</p>	K 0073	The Eternal Candle has been removed from the Chapel The Director of Plant Operations is responsible for the correction of this deficiency	08/26/2016

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K 0074 SS=E Bldg. 01	<p>Manager, and the Maintenance Technician #1 on 08/15/16 between 9:58 a.m. and 12:47 p.m., the Chapel contained multiple candles and only one was lit with no staff member in the chapel. Based on interview, the Administrator confirmed that the candle is always lit and sometimes unattended.</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 are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13</p> <p>o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2.</p> <p>o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3</p>			

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K 0076 SS=D Bldg. 01	<p>o Newly introduced upholstered furniture and mattresses means purchased since March, 2003.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 curtains in the Chapel was flame retardant. This deficient practice could affect staff and up to 20 residents.</p> <p>Findings include:</p> <p>Based on observations with the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 on 08/15/16 between 9:58 a.m. and 12:47 p.m., there were drapes in the Chapel. Based on interview at the time of observation, the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 acknowledged the aforementioned condition and confirmed there was no documentation was available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p>	K 0074	<p>The drapery has been removed from the Chapel</p> <p>The Director of Plant Operations is responsible for the correction of this deficiency</p>	08/25/2016

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	<p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4</p> <p>1. Based on observation and interview, the facility failed to ensure oxygen stored in 1 of 1 sprinklered oxygen storage/transfer room was separated from combustibles by at least 5 feet. NFPA 99, 8-3.1.11.2(c)(2) requires storage for nonflammable gases shall have a minimum distance of 5 feet from combustibles or incompatible materials. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 on 08/15/16 at 12:02 p.m., the oxygen storage/transferring room contained oxygen tanks three feet away from three cardboard boxes. Based on an interview at the time of observation, the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview,</p>	K 0076	<p>A cart to hold Oxygen cylinders has been purchased and put in place on August 29th The oxygen room will marked off and delineated on the floor to keep combustibles out of the range of Five feet from Oxygen containers Combustibles have been removed from the Five foot range Signs will be posted and a weekly spot check will be done to insure compliance The spot checks will be reported to the CQI committee on a quarterly basis for four quarters to further insure compliance The Director of Plant Operations will be responsible for the correction of this deficiency</p>	09/02/2016

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K 0104 SS=F Bldg. 01	<p>the facility failed to ensure 1 of 1 oxygen transfill room containing cylinders of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 on 08/15/16 at 12:02 p.m., the oxygen transfill room had one oxygen cylinder that was freestanding on the floor. Based on interview at the time of observation, the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5.</p>			

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	<p>Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5</p> <p>Based on interview, the facility failed to ensure an undetermined number of dampers in the ductwork at smoke barriers and fire barriers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A to protect 32 of 32 residents. LSC 19.5.2.1 refers to Section 9.2. LSC 9.2.1 requires air conditioning, heating, ventilating 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 shall be removed; all dampers 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 affects all residents, staff and visitors.</p> <p>Findings include: Based on observation with the Director of</p>	K 0104	All dampers in Dujarie will be inspected and fuse links removed to verify proper closure and compliance with this rule The results of this inspection will be reported to the CQI committee to verify compliance The Director of Plant Operations will be responsible for the correction of this deficiency	09/02/2016

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K 0130 SS=E Bldg. 01	<p>Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 on 08/15/16 between 11:32 a.m. and 12:32 p.m., a damper was discovered in the Laundry's Mechanical room, near resident room 121 fire barrier above the drop ceiling, and the Swartz fire barrier above the drop ceiling. Based on interview at the time of each observation, the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 acknowledged the aforementioned condition and confirmed no documentation was available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 2 of 5 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires,</p>	K 0130	<p>All areas identified will be treated with Fire Caulk Entire building will be reviewed and assessed to determine all areas are in compliance with this rule The results of this assessment will be reported to the CQI committee for next two quarters The Director of Plant Operations is responsible for the correction of this deficiency</p>	09/02/2016

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	<p>air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect at least 23 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 on 08/15/16</p>			

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K 0144 SS=F Bldg. 01	<p>at 12:32 p.m. then again at 1238 p.m., two separate half inch penetrations inside conduit in the Schwartz fire barrier above the drop ceiling. Additionally, a half inch penetration around a pipe in in the Schwartz fire barrier above the drop ceiling. Then again, a four inch by eighteen inch piece of drywall was missing from the fire barrier near resident room 120 above the drop ceiling. Based on interview at the time of each observation, the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 acknowledged each aforementioned condition and provided the measurements.</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)</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work</p>	K 0144	<p>The remote annunciator panel will be removed from the Rehabilitation managers office and relocated to the Dujarie Nurses Station which staffed 24 hours a day The Director of Plant Operations is responsible for the correction of this deficiency</p>	09/02/2016

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K 0147 SS=D Bldg. 01	<p>station. This deficient practice could affect all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 on 08/15/16 at 10:26 a.m., the generator annunciator panel was located in the Rehabilitation Manager's office. Based on an interview at the time of observation, the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 acknowledged the aforementioned condition and confirmed that the room is unattended after hours.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and</p>	K 0147	The cords and surge protectors in question were removed The observation of surge protectors has been added to the Preventative Maintenance checklist on a weekly basis Any cords or surge protectors will be removed immediately and reported to the Director of Plant Operations The Director of Plant	09/07/2016

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	<p>cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 on 08/15/16 at 11:51 a.m., a surge protector was powering another surge protector in the Life Enrichment room. Based on interview at the time of observation, the Director of Plant Operations, the Plant Operations Manager, and the Maintenance Technician #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>operations will report on the finding for the next 4 quarters The Director of Plant Operations is responsible for the correction of this deficiency</p>		