

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/07/2014
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NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN 47460
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey with 42 CFR 483.70(a).</p> <p>Survey Date: 11/07/14</p> <p>Facility Number: 010892 Provider Number: 155661 AIM Number: 200229560</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this LSC survey, Owen Valley Health Campus 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.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, sleeping rooms and spaces open to the corridors. The facility has the capacity for 113 and had a census of 88 at the time of this survey.</p>	K010000	<p>The submission of this plan of correction does not indicate an admission by Owen Valley Health Campus that the findings and allegations contained here in are an accurate and true representation of the quality of care provided and living environment provided to the residents of Owen Valley Health Campus. This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K010018 SS=E	<p>All areas where the residents have customary access were sprinklered except those cited at K56. All areas providing facility services were sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</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 regulations in all health care facilities.</p> <p>1. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 5 smoke compartments could automatically latch into the door frame. This deficient practice affects staff, visitors and 10 or more residents in the Legacy smoke compartment.</p> <p>Findings include:</p>	K010018	K 0018 Residents, staff or visitors suffered no ill effects from the alleged deficient practice. 1. The latch was readjusted to assure proper closure of door into door frame. Director of Plant Operations or Designee will complete audits of the double door set between the Legacy corridor and the linen storage closet to assure the door equipment latches into the	12/07/2014			

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	<p>Based on observation with the maintenance director on 11/07/14 at 10:45 a.m., each door in the double door set between the Legacy corridor and the linen storage closet was equipped with an automatic latch. When latch function was tested with the maintenance director at the time of observation, one door latch repeatedly failed to latch into the door frame. The maintenance director acknowledged at the time of observation, each door could not latch automatically into the door frame.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure corridor doors in 1 of 5 smoke compartment would resist the passage of smoke. This deficient practice affects staff, visitors and 10 or more residents in the Legacy smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/07/14 at 11:00 a.m., doors protecting corridor openings to rooms 400 and 401, used as storage rooms on the Legacy Hall. Doors to each room had a 1/4 inch diameter hole in the door where the door knob</p>		<p>door frame to protect smoke compartment. Audits will be completed by the DPO/or Designee 5 times a week for 4 weeks, 1 X weekly for 8 weeks then 1 X monthly for 3 months and quarterly thereafter to assure proper closure with latches into the door frame. Results forwarded to the QAA committee monthly x6 months and quarterly thereafter for review. 2. Doors protecting corridor openings to rooms 400 and 401 located at the north end of 400 hall used as storage rooms on the Legacy Lane had door knob flanges replaced to fully cover holes from previous flanges. Therefore designed to maintain the smoke resistance of the door. Completion Date 12/07/14</p>		

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K010029 SS=E	<p>flanges failed to cover the holes. The holes in the doors to both rooms were stuffed with a paper material resembling tissue. The maintenance director acknowledged at the time of observations, these holes were not sealed with a material designed to maintain the smoke resistance of the door.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ 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 Based on observation and interview, the facility failed to ensure doors to</p>	K010029	K 0029 Residents, staff, and visitors suffered no ill effects	12/07/2014			

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K010038 SS=E	<p>hazardous storage rooms in 1 of 5 smoke compartments self closed to prevent the passage of smoke. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 10 or more residents in the Legacy smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/07/14 at 12:10 p.m., the Legacy shower room was used for the collection of soiled linens in an over flowing 40 gallon receptacle. One of two doors separating the room from the exit corridor had no self closer. The maintenance director acknowledged at the time of observation, the door closer was missing.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		<p>from this alleged deficient practice. Legacy Lane shower room used for hazardous storage with the doors separating the room from the exit corridor had door closer placed to assure doors of smoke compartments will self-close to prevent the passage of smoke. Completion date 12/7/2014.</p>		

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	<p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure locked exit doors in 1 of 5 smoke compartments unlocked upon entry of a code into the keypad adjacent to the door. LSC 19.2.2.2.5 requires doors allowed to be locked in a means of egress shall have adequate provisions made for the rapid removal of occupants by means such as remote control of locks, keying of all locks to be carried by staff at all times, or other such reliable means available to the staff at all times. This deficient practice affects staff, visitors, and 10 or more residents on the Legacy hall.</p> <p>Findings include:</p> <p>Based on observation of the north exit from Legacy wing with the maintenance director on 11/07/14 at 11:15 a.m., the north exit door was equipped with a magnetic door lock designed to release upon activation of the fire alarm, a power outage and a code entered into the keypad adjacent to the exit door. The maintenance director twice attempted to open the door using the code. The door did not open. The door could be opened upon activation of the fire alarm. The maintenance director agreed at the time</p>	K010038	K0038 Residents, staff, and visitors suffered no ill effects from this alleged deficient practice. The north exit door on Legacy Lane is equipped with a magnetic door lock that has been reset to the master code to release via the keypad. Director of Plant Operations or Designee will complete audits to ensure master code releases north exit emergency door on Legacy Lane. Audits will be completed 5x per week for 4 weeks, 1x weekly for 8 weeks, 1x monthly for 3 months, and quarterly thereafter. Results forwarded to the QA meeting monthly x6 months and then quarterly thereafter for review and further suggestions. Completion date 12/7/2014.	12/07/2014			

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K010046 SS=E	<p>of observations, the locking mechanism and keypad override were malfunctioning.</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 observation and interview, the facility failed to ensure 1 of 1 battery powered emergency lighting fixture for the southeast exit discharges would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors, staff and 21 residents on Wings 3, 6 and 8.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/07/14 at 3:00 p.m., one bulb in the two bulb generator powered emergency discharge lighting fixture was shattered with shards of glass on the ground outside one of two exit</p>	K010046	<p>K 0046 Residents, staff, and visitors have suffered no ill effects from the alleged deficient practice. The bulbs were replaced in the emergency discharge lighting fixture outside one of two exit discharges for the southeast smoke compartment. The Director of Plant Operations or Designee will complete audits of southeast smoke compartment to ensure bulbs are in place and in working order to illuminate the path of discharge. Audits completed 5x per week for 4 weeks, 1x weekly for 8 weeks, and 1x monthly for 3 months, and quarterly thereafter. Results will be forwarded to QA monthly for 6 months and quarterly thereafter for review and further suggestions. Completion date 12/7/2014.</p>	12/07/2014

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K010050 SS=C	<p>discharges for the southeast smoke compartment. The maintenance director said at the times of observation, he did not know the light bulb had been broken and acknowledged the fixture could not illuminate the path of discharge if the second bulb were to fail.</p> <p>3.1-19 (b)</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 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 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 2 of the last 4 quarters. This deficient practice could affect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p>	K010050	K 0050 Residents, staff, and visitors suffered no ill effects from this alleged deficient practice. Fire Drills will be held quarterly on each shift by Director of Plant Operations or Designee and documentation of fire drill records will be completed and provided monthly to administrator with results forwarded to QA monthly for review and further suggestions. Completion date	12/07/2014			

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K010054 SS=E	<p>Based on review of the facility's Fire Drill Log/Record of Drills with the maintenance director on 11/07/14 at 3:10 p.m., there was no record of second shift fire drills during the fourth quarter of 2013 and the first quarter of 2014. No third shift fire drill was found for the fourth quarter of 2013. The maintenance supervisor acknowledged fire drill records were not complete and said he had provided all fire drill documentation he could find.</p> <p>3.1-9(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 smoke detectors located in the front lounge and connected to the fire alarm system was properly separated from an air supply or</p>	K010054	<p>12/7/2014.</p> <p>K 0054 Residents, staff, and visitors suffered no ill effects from this alleged deficient practice. The smoke detector located in the boiler room near the kitchen that has an air vent within 10 inches</p>	12/07/2014			

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K010056 SS=E	<p>return vent. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect at least 10 residents as well as staff and visitors using the front lounge.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director at 2:55 p.m. on 11/07/14, the smoke detector located in the boiler room near the kitchen was 10 inches from a ceiling air vent. The maintenance director acknowledged at the time of observation, the maintenance director acknowledged the close proximity of the smoke detector and air vent could affect air flow and interfere with smoke detector function.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is</p>		had a deflector installed to prevent airflow to stop possible interference with smoke detector function. Completion date 12/7/2014.		

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	<p>installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to provide complete sprinkler coverage for 1 of 6 smoke compartments in a one story building of Type V (111) construction. LSC 19.1.6.2 requires one story facilities of Type V (111) construction be provided with complete sprinkler protection. This deficient practice affects residents, staff, and 10 or more residents in the Legacy smoke compartment which includes the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/07/14 at 12:15 p.m., sprinkler protection was not provided for four shower stalls in the Legacy shower room. The maintenance director acknowledged at the time of observation, these shower stalls were not protected by the other sprinklers in the</p>	K010056	K 0056 Residents, staff, and visitors suffered no ill effects from this alleged deficient practice. 1) Sprinkler system updated with new sprinkler heads installed to provide complete sprinkler coverage in Legacy Lane shower room. This work is to be completed by Koorsen with a completion date of 12/7/2014.2) Sprinkler head adjacent to wall in Therapy room was removed and capped. Sprinkler head that remains provides adequate sprinkler coverage for this area as required. This work completed by Koorsen with a completion date of 12/7/20174.	12/07/2014			

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	<p>room.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain the minimum distance between sprinklers in 1 of 5 smoke compartments. NFPA 13, 1999 Edition at 4-7.3.4 requires sprinklers shall be spaced not less than 6 feet on center. This deficient practice affects staff, visitors and 10 or more residents in the northeast smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/07/14 at 12:40 p.m., two pendant ceiling sprinkler heads were spaced 55 inches apart from one another in the Physical therapy room. The maintenance director agreed at the time of observation, the sprinkler heads were not at the minimum distance of six feet apart.</p> <p>3.1-19(b)</p>			
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K010062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 5 smoke compartments free of foreign materials, such as paint and grime. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 20 or more residents in the Legacy and southeast smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/07/14 between 12:15 p.m. and 3:00 p.m.:</p> <p>a. Four sprinkler heads in the Legacy shower room and three sprinkler heads in the laundry were coated with a with a gray fuzzy grime,</p> <p>b. Sprinkler heads in the activities office and in the corridor outside the beauty shop had paint on the deflectors.</p> <p>The maintenance director acknowledged at the time of observations, the sprinkler heads were not free of foreign materials.</p> <p>3.1-19(b)</p>	K010062	<p>K 0062 Residents, staff, and visitors suffered no ill effects from this alleged deficient practice. a) Sprinkler heads in the Legacy Lane shower room and three sprinkler heads in the laundry room were replaced to ensure they are free of gray fuzzy grime. b) Sprinkler heads and deflectors were replaced in activity office and the corridor outside of the beauty shop to ensure that all said sprinkler heads and deflectors are free of foreign materials. Completion date 12/7/2014.</p>	12/07/2014			

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K010064 SS=E	<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</p> <p>1. Based on observation and interview, the facility failed to ensure monthly checks were provided for all portable fire extinguishers in 1 of 5 smoke compartments. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check that an extinguisher is available and will operate. This deficient practice could affect affect visitors, staff and 10 or more residents in the Legacy smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/07/14 at 12:00 p.m., the service and inspection tag for the portable fire extinguisher located</p>	K010064	<p>K 0064 Residents, staff, and visitors suffered no ill effects from this alleged deficient practice. 1) The portable fire extinguisher located in the Legacy Lane medicine room will have monthly checks completed by the Director of Plant Operations or Designee and initialed for date of inspection to ensure that the extinguisher is available and will operate. Executive Director of Designee to complete random audits of portable fire extinguishers to ensure inspections and correlating signatures are completed monthly. Audits will be completed 1x per months for 6 months and quarterly thereafter. Results will be forwarded to QA monthly x6 months and quarterly thereafter for review and further suggestions. 2) Portable fire extinguisher located in the beauty shop was removed and replaced at height of 60 inches above the floor to ensure compliance with height limit for fire extinguishers</p>	12/07/2014

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NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN 47460			
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	<p>in the Legacy medicine room indicated the last monthly check was done in June of 2014. The maintenance director said at the time of observation, he had no idea the outdated fire extinguisher was in the room.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure all fire extinguisher in 1 of 5 smoke compartments were installed as required. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires that the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be no more than three and one half feet (42 inches) above the floor. This deficient practice affects visitors, staff and 10 or more residents in the northeast smoke compartment.</p> <p>Findings include:</p> <p>Based on with the maintenance director 11/07/14 at 3:05 p.m., the portable fire extinguisher in the beauty shop was measured at 62 inches above the finished floor. The maintenance director said at the time of observation he was unaware there was a height limit for fire</p>		mounted to the wall. Completion date 12/7/2014.				

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K010066 SS=E	<p>extinguishers mounted to the wall.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, interview, and record review, the facility failed to provide an enforceable written smoking</p>	K010066	K 0066 Residents, staff, and visitors suffered no ill effects of this alleged deficient practice.All	12/07/2014

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K010067 SS=C	<p>policy for the protection of 88 of 88. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 11/07/14 at 3:15 p.m., a grassy sloped bank between the parking lot and east side of the building was littered with cigarette butts. The maintenance director said at the time of observation the facility was a "no smoking campus". A review of the Owen Valley/ Non smoking policy with the maintenance director on 11/07/14 at 3:20 p.m., confirmed smoking was not permitted on campus but the butts were evidence of a failure to prevent the smoking or at least provide proper receptacles for the safe disposal of cigarette waste.</p> <p>3.1-19(b)</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>staff in-serviced/re-educated on company's no-smoking policy to include area around campus grounds. New signage posted at main entry doors stating No Smoking Within 8 feet of entry. Visitors and residents' family members notified via family newsletter noting campus is smoke-free including campus grounds. Director of Plant Operations or Designee to complete rounds outside of campus on grounds to ensure compliance with no-smoking policy 5x per week for 4 weeks, 1x weekly for 8 weeks, 1x monthly for 3 months, and quarterly thereafter. Results will be forwarded to QA monthly for 6 months and quarterly thereafter for review and further suggestions. Completion date 12/7/2014.</p>	

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	<p>Based on record review and interview, the facility failed to ensure dampers in the ductwork serving 5 of 5 smoke compartments were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. 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 (where applicable) 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 occupants.</p> <p>Findings include:</p> <p>A review of contractor Periodic Fire Inspection Reports with the maintenance director on 11/07/14 at 3:25 p.m. provided no evidence of an inspection and tests of smoke barrier fire dampers found. The maintenance director said at the time of record review, he had not found any documentation the dampers had been inspected. He said he had</p>	K010067	K 0067 Residents, staff, and visitors suffered no ill effects from this alleged deficient practice. Inspection and tests of smoke barrier fire dampers with documentation to be completed by Koorsen to ensure all dampers are in working order. Completion date 12/7/2014.	12/07/2014			

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K010147 SS=E	<p>contracted for the service to be done "next week". He provided a documented proposal for the service by the fire system contractor dated 11/04/14 and an e-mail from the same contractor to arrange the damper inspection for 11/13/14 and 11/14/14. He acknowledged that, until the work was done it could not be ensured the dampers were all working.</p> <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 maintain an electrical outlet in 1 of 5 smoke compartments. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects visitors, staff and 10 or more residents in the south east smoke compartment.</p> <p>Findings include: Based on observation with the maintenance director at 2:55 p.m. on</p>	K010147	K 0147 Residents, staff, and visitors suffered no ill effects from this alleged deficient practice.A face plate was immediately placed, by the Director of Plant Operations, over electric receptacle in boiler room near the kitchen. Leadership team in-service completed to notify Director of Plant Operations if face plate is removed or damaged. Completion date 12/7/2014.	12/07/2014

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	11/07/14, an electric receptacle in the boiler room wall near the kitchen was uncovered. The maintenance director acknowledged at the time of observation, the wiring should have been protected by a face plate. 3.1-19(b)				