

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/14/2014
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NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260
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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: 04/14/14</p> <p>Facility Number: 000074 Provider Number: 155154 AIM Number: 100290050</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Spring Mill Meadows 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 two story facility with a basement was determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 142 and had a census of 106 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached storage shed providing facility</p>	K010000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after April 30, 2014</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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K010018 SS=E	<p>storage services which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/15/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: 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 1¼ 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>Based on observation and interview, the facility failed to ensure 5 of over 75 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing and latching, and would resist the passage of smoke. This deficient practice could affect 50 residents, staff and visitors on the second floor.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from</p>	K010018	<p>K018 NFPA 101Life Safety Code Standard</p> <p>Doors protecting corridor opening in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 ¾ 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</p>	04/30/2014

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	<p>12:45 p.m. to 4:00 p.m. on 04/14/14, the following was noted:</p> <p>a. the corridor door to the Clean Linen Room by Room 237 had a 1/8th inch in diameter hole above the door handle.</p> <p>b. the corridor door to the second floor Activities Room had two 1/8th inch in diameter holes above and below the door handle.</p> <p>c. the corridor door to Room 230 was propped in the fully open position with a wooden wedge and the corridor door to the basement storage room by the Maintenance Office was propped in the fully open position with a burlap bag.</p> <p>d. the corridor door to the basement Storage Room Housekeeping Supplies was not equipped with a positive latching device. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned corridor doors failed to resist the passage of smoke, provided an impediment to closing and latching or were not equipped with a positive latching device to latch the door into the door frame.</p> <p>3.1-19(b)</p>		<p>closes. Dutch doors meeting 19.3.6.3.6 arepermitted. Roller latches are prohibited by CMS regulations in all health carefacilities.</p> <p>What corrective action(s) will be accomplished forthose residents found to have been affected by the deficient practice?</p> <p>The 1/8 inch hole in thecorridor door to the Clean Linen Room was filled with wood filler.</p> <p>The 2 1/8 inch holes aboveand below the door handle on the 2nd floor Activities Room door werefilled with wood filler.</p> <p>The wedge propping open theroom 230's door has been removed.</p> <p>A push button door latch wasinstalled on the corridor door to the basement storage room and they burlap bagwas removed.</p> <p>A door latch was installed tothe corridor door to the basement storage room for Housekeeping supplies.</p> <p>How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken?</p> <p>Allresidents residing on the 2nd floor have the potential to beaffected by the alleged deficient practice.</p>	

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			<p>MaintenanceDirector inspected all corridor doors in the facility to ensure they latchappropriately and are not propped open.</p> <p>What measures will be put into place or what systemicchanges will you make to ensure that the deficient practice does not recur.</p> <p>Maintenance Director has beenin-serviced on ensuring that all corridor doors are provided with a meanssuitable for keeping the door closed, has no impediment to closing andlatching, and will resist the passage of smoke.</p> <p>Maintenance Director willmake rounds weekly x 4 and the monthly thereafter to ensure all corridor doorsare provided with a means suitable for keeping the door closed, has noimpediment to closing and latching, and will resist the passage of smoke.</p> <p>Maintenance Director/Designee will educate staff by April 30, 2014 on ensuring corridor doors are not blockedor propped open.</p> <p>How will the corrective action(s) be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place</p> <p>The CQI Committeewill review the results to make sure all corridor</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 openings through 2 of 8 smoke barrier walls were protected to maintain the one half hour fire resistance of the smoke barrier. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 60 residents, staff and</p>	K010025	<p>doors are provided with ameans suitable for keeping the door closed, has no impediment to closing andlatching, and will resist the passage of smoke to ensure compliance. If compliance isnot achieved, an action plan will be developed to ensure compliance.</p> <p>Compliance date: April 30, 2014</p> <p>K025 NFPA 101Life 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 anatrium wall. Windows protected by fire-rated glazing or b wired glass panelsand steel frames. A minimum of two separate compartments are provided on eachfloor. Dampers are no required in duct penetrations of smoke barriers in fullyducted heating, ventilating, and air conditioning systems.</p>	
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	<p>visitors on the second floor.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 4:00 p.m. on 04/14/14, the following openings were noted which did not provide at least a one half hour fire resistance rating for the smoke barrier wall:</p> <p>a. a twelve inch by twelve inch hole for the passage of a ten inch in diameter duct in the smoke barrier wall above the ceiling by the smoke barrier door set by Room 203.</p> <p>b. a twenty inch by twelve inch hole for the passage of two ten inch in diameter ducts in the smoke barrier wall above the ceiling by the smoke barrier door set by Room 217. In addition, a six inch hole for the passage of six cables was noted at the aforementioned smoke barrier wall location.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned openings in smoke barrier walls 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 1 of 3 ceiling smoke barriers was protected to maintain the fire resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>All holes in the smokebarrier walls have been filled with firestop to provide a one half hour fireresistant rating.</p> <p>The five diameter conduits for the passage of cables were filled with fire stop to ensure ceiling smokebarrier is smoke resistant.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents on the 2nd floor have the potential to be affected by the alleged deficient practice. All smoke barrier walls were inspected by the Maintenance Director to ensure there are no other openings in smoke barrier walls.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur.</p> <p>Maintenance Director will be serviced on ensuring that all smoke barrier walls are protected to maintain a one half hour fire resistance of smoke barriers. Maintenance Director by Executive Director by April 30, 2014.</p>	

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	<p>34 residents, staff and visitors in the vicinity of the first floor electrical room by Room 116.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 4:00 p.m. on 04/14/14, five two inch in diameter conduits for the passage of cables were not filled with a material capable of maintaining fire resistance or protected by an approved device. In addition, the one quarter inch annular space surrounding each of the five conduits was not smoke resistant. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned openings failed to maintain the smoke resistance of the ceiling smoke barrier.</p> <p>3.1-19(b)</p>		<p>Maintenance Director will bein-serviced by Executive Director by April 30, 2014 on ensuring that allpassage of building service materials such as pipe, cable or wire are to beprotected to the space between the penetrating item and the smoke barrier willbe filled with a material capable of maintaining the smoke resistance of thesmoke barrier.</p> <p>Maintenance Director willmake rounds make rounds weekly x 4 and monthly thereafter to ensure that allsmoke barrier walls are protected to maintain a one half hour fire resistanceof smoke barriers.</p> <p>Maintenance Director willmake rounds weekly x 4 and monthly thereafter to ensure that all passage ofbuilding service materials such as pipe, cable or wire are to be protected tothe space between the penetrating item and the smoke barrier will be filledwith a material capable of maintaining the smoke resistance of the smokeybarrier.</p> <p>How will the corrective action(s) be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place</p> <p>The CQI Committee will reviewthe results ensure that all passage of</p>	

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K010029 SS=D	<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</p> <p>Based on observation and interview, the facility failed to ensure 2 of 13 hazardous areas such as combustible storage rooms over 50 square feet in size were separated from other areas by smoke resistant partitions and equipped with positive latching devices on entry room doors which latched securely into their door frames. This deficient practice could affect 5 staff and visitors in the basement.</p> <p>Findings include:</p>	K010029	<p>building service materials such as pipe,cable or wire are to be protected to the space between the penetrating item andthe smoke barrier will be filled with a material capable of maintaining thesmoke resistance of the smoke barrier.</p> <p>If compliance isnot achieved, an action plan will be developed to ensure compliance. Compliance date: April 30, 2014</p> <p>K029 NFPA 101Life Safety Code Standard One hour fire rated construction (with ¾ hour fire-rated doors) or anapproved automatic fire extinguishing system in accordance with 8.4.1 and/or19.3.5.4 protects hazardous areas. When the approved automatic fireextinguishing system option is used, the areas are separated from other spacesby smoke resisting partitions and doors. Doors are self-closing and non-ratedor field-applied protective plates that do</p>	

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	<p>Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 4:00 p.m. on 04/14/14, the following was noted:</p> <p>a. the basement Storage Room Housekeeping Supplies room measured over 190 square feet, was used to store linen and combustible supplies and the corridor door was not equipped with a positive latching device.</p> <p>b. the basement storage room by the Maintenance Office measured over 500 square feet, was used to store mattresses, plastic carts and combustible supplies and was propped in the fully open position with a burlap bag.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned hazardous areas were not separated from other spaces by smoke resistant partitions and doors equipped with a positive latching device.</p> <p>3.1-19(b)</p>		<p>not exceed 48 inches from the bottom of the door are permitted.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Both of the storage rooms in the basement are clean and free of clutter.</p> <p>A push button door latch was installed on the corridor door to the basement storage room and the burlap bag was removed.</p> <p>A door latch was installed to the corridor door to the basement storage room for Housekeeping supplies.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Residents have the potential to be affected by the alleged deficient practice.</p> <p>Staff and visitors visiting the basement have the potential to be affected by the alleged deficient practice.</p> <p>Maintenance Director will be in-services by the Executive Director by April 30, 2014 ensuring that all hazardous areas are separated by smoke resistant partitions and</p>		

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			<p>equipped with positive latching devices on entry room doors which latchsecurely into their door frames.</p> <p>What measures will be put into place or what systemicchanges will you make to ensure that the deficient practice does not recur.</p> <p>MaintenanceDirector will be in-services by the Executive Director by April 30, 2014 onensuring that all hazardous areas are separated by smoke resistant partitionsand equipped with positive latching devices on entry room doors which latchsecurely into their door frames.</p> <p>Maintenance Director willmake rounds weekly x 4, monthtly x 6, and quarterly thereafter to ensure that all hazardous areas are separated bysmoke resistant partitions and equipped with positive latching devices on entryroom doors which latch securely into their door frames.</p> <p>MaintenanceDirector will make rounds weekly to ensure the storage rooms remain clean andfree of clutter.</p> <p>How will the corrective action(s) be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place</p> <p>The CQI Committee will reviewthe results to ensure that allhazardous areas are separated by smoke</p>	

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is 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>Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 5-6.5 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-6.5.2 and 5-6.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could affect 34 residents, staff and visitors in the vicinity of the Whirlpool Room by Room 115.</p>	K010056	<p>resistant partitions and equipped with positive latching devices on entry room doors which latch securely into their door frames.</p> <p>If compliance is not achieved, an action plan will be developed to ensure compliance. Compliance date: April 30, 2014</p> <p>K056 NFPA 101 Life Safety Code Standard If there is an automatic sprinkler system, it is installed in accordance with the 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 Inspections, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable,</p>	

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 4:00 p.m. on 04/14/14, a shower curtain was hung from the ceiling of the Whirlpool Room by Room 115 which obstructed the sprinkler coverage for half the room. Based on interview at the time of observation, the Maintenance Director acknowledged the shower curtain obstructed the discharge pattern which did not ensure complete sprinkler coverage for the Whirlpool Room by Room 115.</p> <p>3.1-19(b)</p>		<p>adequate water supply for the system. Requiredsprinkler systems are equipped with water flow and tamper switches, which areelectrically connected to the building fire alarm system.</p> <p>What corrective action(s) will be accomplished forthose residents found to have been affected by the deficient practice?</p> <p>A new mesh shower curtain wasinstalled in the Whirlpool Room. The sprinkler coverage for the room is nolonger obstructed.</p> <p>An inspection of allsprinkler heads and shower rooms were inspected by the Maintenance Director toensure there was no obstruction to discharge.</p> <p>How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken?</p> <p>Allresidents have the potential to be affected by the alleged deficient practice.</p> <p>MaintenanceDirector will be in-serviced by the Executive Director by April 30, 2014 on ensuringthat the sprinkler system is installed properly and is located as to minimizeobstructions to discharge.</p> <p>What measures will be put into place or what systemicchanges will</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/14/2014
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
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K010144 SS=C	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. Based on observation, record review and interview; the facility failed to ensure the	K010144	<p>you make to ensure that the deficient practice does not recur.</p> <p>MaintenanceDirector will be in-serviced by the Executive Director by April 30, 2014 onensuring that the sprinkler system is installed properly and is located as tominimize obstructions to discharge.</p> <p>Maintenance Director willmake rounds weekly to ensure that thesprinkler system is installed properly and is located as to minimizeobstructions to discharge.</p> <p>How will the corrective action(s) be monitored toensure the deficient practice will not recur, i.e., what quality assurance programwill be put into place</p> <p>The CQI Committee will reviewthe results to ensure that thesprinkler system is installed properly and is located as to minimizeobstructions to discharge.</p> <p>If compliance isnot achieved, an action plan will be developed to ensure compliance.</p> <p>Compliance date: April 30, 2014</p> <p>K144 NFPA 101Life Safety Code Standard Generators are inspected weekly and exercised under load for 30</p>		

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	<p>reliable source documentation for the off site fuel source for 1 of 1 emergency generators was signed by a person with the technical expertise to make the reliable source claim. NFPA 110, 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <p>a) Liquid Petroleum products at atmospheric pressure</p> <p>b) Liquefied petroleum gas (liquid or vapor withdrawal)</p> <p>c) Natural or synthetic gas</p> <p>Exception: For Level 1 installations in locations where the probability of interruption of offsite fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:</p> <ol style="list-style-type: none"> 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption. 5. The signature of a technical person from the natural gas provider. <p>This deficient practice could affect all</p>		<p>minutes per month in accordance with NFPA 99.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The facility has obtained documentation for the offsite fuel source that is signed by a person with technical expertise.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>The facility has obtained documentation for the offsite fuel source that is signed by a person with technical expertise.</p> <p>Maintenance Director will be in-serviced by the Executive Director by April 30, 2014 on ensuring that the natural gas provider letter is signed by a person with the technical expertise to make the reliable source claim.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur.</p>	

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K010147 SS=E	<p>residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Citizens Gas & Coke Utility natural gas supplier letter dated 01/31/96 with the Maintenance Director during record review from 9:50 a.m. to 11:45 a.m. on 04/14/14, the natural gas provider letter was signed by the "Counsel for Administrative Affairs." Based on interview at the time of record review, the Maintenance Director stated the fuel source for the emergency generator was natural gas, no additional supplier reliability documentation was available for review and acknowledged the natural gas provider letter was not signed by a person with the technical expertise to make the reliable source claim. Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 4:00 p.m. on 04/14/14, the fuel source for the emergency generator was confirmed to be natural gas.</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</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a</p>	K010147	<p>MaintenanceDirector will be in-serviced by the Executive Director by April 30, 2014 onensuring that the natural gas provider letter is signed by a person with thetechnical expertise to make the reliable source claim.</p> <p>The document will be reviewed annually by Maintenance Director to ensure the letteris signed by a person with the technical expertise to make the reliable sourceclaim.</p> <p>How will the corrective action(s) be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place?</p> <p>The facility has obtaineddocumentation for the off site fuel source that is signed by the GeneralManager of Engineering dated 4/22/14.</p> <p>•Compliance date: April 30, 2014</p> <p>K147 NFPA 101Life Safety Code Standard Electrical wiring and equipment is in accordance with NFPA 70, NationalElectrical Code.</p>	

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	<p>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 10 residents, staff and visitors in the vicinity of the first floor Therapy Room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 4:00 p.m. on 04/14/14, the following was noted:</p> <p>a. a microwave oven and a refrigerator were plugged into a power strip in the first floor Therapy Room.</p> <p>b. a coffee pot and a refrigerator were plugged into a power strip in the first floor Director of Nursing Services Office.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged power strips were being used as a substitute for fixed wiring at the aforementioned locations.</p> <p>3.1-19(b)</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The microwave and oven in the 1st floor Therapy Room are no longer plugged into a power strip. The coffee pot and refrigerator in the Director of Nursing Services office are no longer plugged into a power strip.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>An inspection of the therapy gyms and offices has been conducted by the Maintenance Director to ensure power strips and/or extension cords are not used as a substitute for fixed wiring.</p> <p>Maintenance Director will be in-serviced by the Executive Director by April 30, 2014 on ensuring that power strips and/or extension cords are not used as a substitute for fixed wiring.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the</p>	

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			<p>deficient practice does not recur.</p> <p>Maintenance Director will be in-serviced by the Executive Director by April 30, 2014 on ensuring that power strips and/or extension cords are not used as a substitute for fixed wiring.</p> <p>Maintenance Director/Designee will in-service staff on ensuring that power strips and/or extension cords are not used as a substitute for fixing wiring.</p> <p>Maintenance Director will make rounds weekly x 4 and monthly thereafter to ensure that power strips and/or extension cords are not used as a substitute for fixing wiring.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>The CQI Committee will review the results to ensure that power strips and/or extension cords are not used as a substitute for fixing wiring.</p> <p>If compliance is not achieved, an action plan will be developed to ensure compliance.</p> <p>Compliance date: April 30, 2014</p>	