

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2014
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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219
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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: 06/20/14</p> <p>Facility Number: 000222 Provider Number: 155329 AIM Number: 100274950</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Rosewalk Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (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. Battery operated smoke detectors are installed in all resident</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 this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after July 9th, 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>sleeping rooms except rooms 201 through 211 which have smoke detectors hard wired to the fire alarm system. The facility has a capacity of 161 and had a census of 149 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two detached wooden sheds providing facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/26/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 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</p>			

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	<p>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. Based on observation and interview, the facility failed to ensure 2 of over 100 corridor doors were provided with a means suitable for keeping the door closed, latched and would resist the passage of smoke. This deficient practice could affect 42 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Assistant Administrator during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/20/14, the following was noted:</p> <p>a. the corridor door to the Nutrition Pantry at the South Nurses Station failed to latch into the door frame because the latching mechanism was removed.</p> <p>b. the corridor door to the storage room by Room 107 had two holes above and below the door handle which were each one half inch in diameter and would not resist the passage of smoke.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the Nutrition Pantry corridor door would not latch into the</p>	K010018	<p>1. The latch on the door to the nutrition pantry was repaired so the door latches and the holes on the storage room door by room 107 were filled and sealed. 2. Residents on D hall and A Hall, staff, and visitors had the potential to be affected by this alleged deficient practice. The latch on the door to the nutrition pantry was repaired so the door latches and the holes on the storage room door by room 107 were filled and sealed. All doors were audited to ensure proper latching and all holes were repaired.3. Any new doors or latching hardware installed will be inspected by the maintenance supervisor/ designee to ensure they are installed properly. 4. Facility maintenance director will audit weekly for 4 weeks, and then monthly for 5 months to ensure that any new doors installed, latching mechanisms, or door hardware have been installed properly. Results of audits will be taken to facility monthly CQI meeting for review5. Maintenance director/ designee is responsible. Completion date 7/9/14.</p>	07/09/2014

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K010025 SS=F	<p>door frame and each of the aforementioned corridor doors would fail to resist the passage of smoke.</p> <p>3.1-19(b)</p> <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>Based on observation and interview, the facility failed to ensure 1 of 1 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</p>	K010025	<p>1. Drywall was installed on affected area in main fire control panel room. The 2 inch space around the gas line above water heater in laundry room was filled with appropriate fire caulk. The 2 inch space around a low point drain in storage rm by rm 107 was filled with fire caulk.</p>	07/09/2014

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	<p>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 all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Assistant Administrator during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/20/14, the following openings were noted in the ceiling smoke barrier:</p> <p>a. an eight inch by three inch wide hole above the Vaccu Break Safety Switch and a two inch wide hole next to a four inch in diameter pipe in the main fire alarm control panel room.</p> <p>b. a two inch in diameter annular space surrounding a one inch in diameter natural gas line above the water heater in the Laundry Room.</p> <p>c. a two inch in diameter annular space surrounding a one inch in diameter low point drain pipe in the storage room by Room 107.</p> <p>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>2. Residents on A hall, staff or visitors had the potential to be affected by this alleged deficient practice. Drywall was installed on affected area in main fire control panel room. The 2 inch space around the gas line above water heater in laundry room was filled with appropriate fire caulk. The 2 inch space around a low point drain in storage rm by rm 107 was filled with fire caulk. All fire control panel rooms were inspected for missing smoke barriers, all water heaters were inspected to ensure gas lines were appropriately caulked, and all low point drains were inspected to ensure all gaps were caulked.</p> <p>3. Maintenance supervisor or designee will be present when new water heaters are installed to ensure any wall damage is appropriately repaired. Maintenance supervisor or designee will be present when any work is done by the Vaccu Break Safety Switch to ensure any wall damage is appropriately repaired. Maintenance supervisor or designee will be present when work is done to the sprinkler system to ensure any wall damage is appropriately repaired</p> <p>4. Fire alarm control panel rooms, low point drain lines, and gas lines to water heaters will be inspected monthly for 6 months to ensure smoke barrier walls are intact. Results of audits will be taken to facility monthly CQI meeting for review.</p>	

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K010029 SS=E	<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</p> <p>Based on observation and interview, the facility failed to ensure ensure 1 of 19 hazardous areas such as fuel fired heater rooms were separated from other spaces by smoke resistant partitions. This deficient practice could affect 16 residents, staff and visitors in the vicinity of the Laundry.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K010029	<p>5. Maintenance director/ designee is responsible. Completion date 7/9/14</p> <p>1. The 2 inch space around the gas line above water heater in laundry room was filled with appropriate fire caulk.</p> <p>2. Residents on A hall, staff or visitors had the potential to be affected by this alleged deficient practice. The 2 inch space around the gas line above water heater in laundry room was filled with appropriate fire caulk. All gas fired water heaters were inspected to ensure the gas lines had no gaps around them.</p> <p>3. Maintenance supervisor or</p>	07/09/2014

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K010038 SS=E	<p>Maintenance Director and Assistant Administrator during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/20/14, the two inch in diameter annular space surrounding a one inch in diameter natural gas line above the water heater in the Laundry was noted which did not separate this hazardous area from other spaces by smoke resistant partitions. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned hole in the ceiling of the Laundry did not separate this area from other spaces by smoke resistant partitions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview,</p>	K010038	<p>designee will be present when new water heaters are installed to ensure any wall damage is appropriately repaired.</p> <p>4. Gas lines to water heaters will be inspected monthly for 6 months to ensure smoke barrier walls are intact. Results of audits will be taken to facility monthly CQI meeting for review.</p> <p>5. Maintenance director/designee is responsible. Completion date 7/9/14</p>	07/09/2014

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	<p>the facility failed to ensure not more than one delayed egress lock device was provided in 1 of 11 egress paths as permitted by NFPA 101, Section 19.2.2.2.4 Exception No. 2. A.19.2.2.2.4 states, the intent of the provision is that a person following the natural path of the means of egress not encounter more than one delayed release device along that path of travel to an exit. Thus, each door from the multiple floors of a building that opens into an enclosed stair is permitted to have its own delayed release device, but an additional delayed release device is not permitted at the level of exit discharge on the door that discharges people from the enclosed stair to the outside. This deficient practice could affect 14 residents, staff and visitors if needing to exit the B Hall by Room 123.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Assistant Administrator during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/20/14, the egress path for the B Hall exit by Room 123 consisted of two separate sets of exit doors and each set of exit doors was provided with a delayed egress lock. Based on interview at the time of the observations, the Maintenance Director acknowledged more than one delayed</p>		<p>on the mag lock by rm 123 exit doors has been inspected and appropriate signage has been posted. The doors exiting the foyer have had a motion detector installed and appropriate signage has also been installed on this door. The code has been posted on the door exiting the therapy room. The door in the therapy room has been inspected and repaired and does release when the fire detection system is activated.2. 22 residents, staff, visitors, and and residents in the therapy room wanting to use the set of exit doors by room 123 had the potential to be affected by this alleged deficient practice. The delayed egress function on the mag lock by rm 123 exit doors has been inspected and appropriate signage has been posted. The doors exiting the foyer have had a motion detector installed and appropriate signage has also been installed on this door. The code has been posted on the door exiting the therapy room. The door in the therapy room has been inspected and repaired and does release when the fire detection system is activated. All exit doors were inspected to make sure that they had appropriate signage posted regarding delayed egress, all doors were inspected to make sure appropriate codes were posted, and all doors were checked to ensure they released when the fire alarm is</p>	

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	<p>egress lock device was provided for the egress path at the B Hall exit by Room 123.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the means of egress through 2 of 6 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual</p>		<p>activated.3. Maintenance director will audit all delayed egress doors and electromagnetically locking doors for proper function thru use of exit door audit.4. Monthly audit will be conducted for 6 months to ensure all delayed egress exit doors are functioning properly. Results of audits will be taken to facility monthly CQI meeting for review.5. Maintenance director/ designee is responsible. Completion date 7/9/14</p>	

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	<p>means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS.</p> <p>This deficient practice could affect 14 residents, staff and visitors if needing to exit the B Hall by Room 123.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Assistant Administrator during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/20/14, the B Hall exit by Room 123 leads to a foyer exit. Each exit was marked as a facility exit and each exit door is equipped with a delayed egress lock but is not provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device. Each exit door released within 15 seconds when the door was pushed with the application of force two separate times. Based on interview at the time of the observations, the Maintenance</p>			

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	<p>Director stated the aforementioned exit doors are each a facility exit, are each equipped with a delayed egress lock and acknowledged the two exits are not provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure the means of egress through 3 of 11 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect 24 residents, staff and visitors if needing to exit the B Hall by Room 123 and from the Therapy Room.</p> <p>Findings include:</p>			

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	<p>Based on observation with the Maintenance Director and Assistant Administrator during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/20/14, the Therapy Room exit and the B Hall exit by Room 123 which leads to a foyer exit were each marked as a facility exit. Each exit door was magnetically locked and could be opened by entering a four digit code, but the code was not posted. Based on interview at the time of observation, the Maintenance Director and Assistant Administrator stated facility residents who have a clinical diagnosis to be in a secure building reside in the Memory Care Hall and acknowledged the four digit code was not posted at the aforementioned facility exits. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.</p> <p>3.1-19(b)</p> <p>4. Based on observation and interview, the facility failed to ensure 1 of 11 exit door electromagnetic locks remained unlocked while the fire alarm was activated. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be</p>			

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	<p>in accordance with Chapter 7. LSC 7.2.1.6.2(e) states activation of the building automatic sprinkler or fire detection system, if provided, automatically unlocks the doors and the doors remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice could affect 10 residents, staff and visitors if needing to exit the Therapy Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Assistant Administrator during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/20/14, the electromagnetic lock on the Therapy Room exit door did not release and remain unlocked when the fire alarm was activated at 3:40 p.m. Based on interview at the time of observation, the Maintenance Director acknowledged the electromagnetic lock on the Therapy Room exit door did not release when the fire alarm system was activated.</p> <p>3.1-19(b)</p>			

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K010045 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to ensure lighting for 1 of 11 exit means of egress, including exit discharge, was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect 10 residents, staff and visitors if needing to exit the facility by the Therapy Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Assistant Administrator during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/20/14, the exit discharge by the Therapy Room to the outside of the building was equipped with one lighting fixture which did not contain a light bulb. Two battery</p>	K010045	<ol style="list-style-type: none"> The light outside of the therapy room exit has been repaired and bulbs installed. All residents, staff, and visitors in the therapy room had the potential to be affected by this alleged deficient practice. The light outside of the therapy room exit has been repaired and bulbs installed. All exit lights have been inspected to ensure they have 2 working bulbs in place. Maintenance director will audit all exit lighting at means of egress to ensure bulbs are in place and functioning properly. Monthly audit will be conducted for 6 months to ensure exit lighting at means of egress is functioning properly. Results of audits will be taken to facility monthly CQI meeting for review. Maintenance director/ 	07/09/2014

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K010046 SS=C	<p>backup lights powered by the facility generator were also noted at the exit by the Therapy Room. Based on interview at the time of observation, the Maintenance Director stated the battery backup lights only illuminate if the building was to lose normal electrical power and acknowledged the Therapy room exit discharge was equipped with one lighting fixture which did not contain a light bulb leaving the area in darkness should the building maintain normal electrical power.</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>1. Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 14 of 14 battery powered lights during the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting</p>	K010046	<p>designee is responsible. Completion date 7/9/14</p> <p>1. All 14 battery operated emergency lights were tested for 30 seconds and do function properly. F Hall annual test for the battery operated emergency light for 1.5 hour duration was performed and functioned properly. Light by rm 137 has been replaced.</p>	07/09/2014

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	<p>Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hr duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Emergency Lights-Test Log for 2013 and 2014" documentation with the Maintenance Director and Assistant Administrator during record review from 9:50 a.m. to 12:15 p.m. on 06/20/14, the following was noted:</p> <p>a. documentation of functional testing for not less than 30 seconds for 14 of 14 battery operated emergency lights for December 2013 was not available for review.</p> <p>b. documentation of an annual test for the F-Hall battery powered emergency light for not less than a 1 ½ hour duration for the most recent twelve month period was not available for review.</p> <p>Based on interview at the time of record</p>		<p>2. All residents, staff, and visitors had the potential to be affected by this alleged deficient practice. All 14 battery operated emergency lights were tested for 30 seconds and do function properly. F Hall annual test for the battery operated emergency light for 1.5 hour duration was performed and functioned properly. Light by rm 137 has been replaced.</p> <p>3. Maintenance director / designee will test all emergency monthly for 30 seconds and yearly to ensure they light appropriately for 1.5 hours.</p> <p>4. Monthly audit will be conducted for 12 months to ensure all emergency lighting is functioning properly. Results of audits will be taken to facility monthly CQI meeting for review.</p> <p>5. Maintenance director or designee is responsible. Completion date 7/10/14</p>	

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	<p>review, the Maintenance Director acknowledged documentation of functional testing for at least 30 seconds for 14 of 14 battery operated emergency lights for December 2013 and annual testing documentation for the F-Hall battery operated light was not available for review. Based on observations with the Maintenance Director and Assistant Administrator during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/20/14, a total of 14 battery operated emergency lights were located in the facility and each battery operated emergency light operated when their respective test button was pushed except for light located at the exit by Room 137.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 14 battery operated emergency lights was maintained in accordance with LSC 7.9. LSC 7.9.2.4 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. This deficient practice could affect 24 residents, staff and visitors in the vicinity of the exit by Room 137.</p> <p>Findings include:</p>			

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K010068 SS=E	<p>Based on observation with the Maintenance Director and Assistant Administrator during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/20/14, the battery powered emergency light located at the exit by Room 137 failed to illuminate when its respective test button was pressed five times. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned battery operated emergency light failed to illuminate when its respective test button was pressed.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 19 hazardous areas such as fuel fired heater rooms was provided with intake combustion air</p>	K010068	<p>1. Venting has been installed to provide intake combustion air taken directly from the outside to the natural gas fired water heater in the laundry room.</p>	07/09/2014
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	<p>taken directly from the outside. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for 16 residents, staff and visitors in the vicinity of the Laundry.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Assistant Administrator during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/20/14, the washing machine room of the laundry contained a natural gas fired water heater. It could not be assured the washing machine room of the laundry was provided with intake combustion air taken directly from the outside. The washing machine room of the laundry was separated from the dryer room of the laundry by two free swinging doors. A combustion air intake was located behind the natural gas fired dryers but the area behind the dryers was separated from the dryer room by smoke resistant partitions and a door. Based on interview at the time of observation, the Maintenance Director stated the only area of the laundry provided with intake combustion air taken directly from the outside was behind the dryers and acknowledged it could not be assured the washing machine room of the laundry was</p>		<p>2. Residents on B hall, staff, and visitors had the potential to be affected by this alleged deficient practice. Venting has been installed to provide intake combustion air taken directly from the outside to the natural gas fired water heater in the laundry room.</p> <p>3. Any natural gas fired water heaters will be inspected by the maintenance supervisor/ designee to ensure they are installed properly and have proper intake combustion air taken directly from the outside. All gas fired water heaters were inspected to ensure they did have appropriate fresh air supplied from the outside.</p> <p>4. Facility maintenance director will audit monthly for 6 months to ensure that any natural gas fired water heaters are installed properly and have proper intake combustion air taken directly from the outside. Results of audits will be taken to facility monthly CQI meeting for review.</p> <p>5. Maintenance director/ designee is responsible. Completion date 7/9/14</p>	

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K010130 SS=C	<p>provided with intake combustion air taken directly from the outside for the natural gas fired water heater.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 92 of 92 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Smoke Detector Maintenance Log for 2013 and 2014" documentation with the</p>	K010130	<ol style="list-style-type: none"> All battery operated smoke detectors have been tested and cleaned, and all operate properly. All residents, staff, and visitors had the potential to be affected by this alleged deficient practice. All battery operated smoke detectors have been tested and cleaned, and all operate properly. All battery operated smoke detectors will be tested monthly and cleaned according to manufacturer recommendations. Facility maintenance director will audit monthly for 6 months for the monthly testing, and monthly up to year for cleaning. Results of audits will be taken to facility 	07/09/2014

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	<p>Maintenance Director and Assistant Administrator during record review from 9:50 a.m. to 12:15 p.m. on 06/20/14, the following was noted:</p> <p>a. documentation of battery operated smoke detector testing for December 2013 was not available for review.</p> <p>b. documentation of battery operated smoke detector cleaning within the most recent twelve month period was not available for review. The most recent documented cleaning of battery operated smoke detectors was in April 2013.</p> <p>Based on observations with the Maintenance Director and Assistant Administrator during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/20/14, battery operated smoke detectors are installed in each of 92 resident sleeping rooms. Manufacturer's specifications affixed to 91 First Alert smoke detectors did not state the required frequency of cleaning. However, the Kidde Model i9040 smoke detector installed in Room 127 stated to clean annually. Based on interview at the time of record review and of the observations, the Maintenance Director stated each battery operated smoke detector is supposed to have annual cleaning but acknowledged documentation of annual cleaning and December 2013 testing was not available for review.</p>		<p>monthly CQI meeting for review.</p> <p>5. Maintenance director/designee is responsible. Completion date 7/9/14</p>	

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K010144 SS=C	<p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review, observation and interview; the facility failed to ensure the reliable source documentation for the off site fuel source for 1 of 1 emergency generators contained a statement regarding reliability, the probability of interruption and 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 b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas</p>	K010144	<p>1. Documentation from Citizens Gas & Coke Utility was provided that addressed reasonable reliability of natural gas, has a description to support the reliability of natural gas supply, thee is low probability of interruption due to 3 pipelines and underground storage facilities, and was provided by the General Manager of Engineering.</p> <p>2. All residents, staff, and visitors had the potential to be affected by this alleged deficient practice. Documentation from Citizens Gas & Coke Utility was provided that addressed reasonable reliability of natural gas, has a description to support the reliability of natural gas supply, thee is low probability of interruption due to 3 pipelines and underground storage facilities, and was provided by the General Manager of Engineering.</p>	07/09/2014			

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	<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.</p> <p>CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:</p> <ol style="list-style-type: none"> 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption. 5. The signature of a technical person from the natural gas provider. <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p>		<ol style="list-style-type: none"> 3. Any changes from from Citizens gas regarding the reliability of the gas supply will be noted and handled appropriately to ensure facility has reliable supply of natural gas. 4. Facility maintenance director will audit monthly for 6 months to ensure the gas supply reliability status has not changed. Results of audits will be taken to facility monthly CQI meeting for review 5. Maintenance director/ designee is responsible. Completion date 7/9/14. 				

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	<p>Based on review of the Citizens Gas & Coke Utility natural gas supplier letter dated 06/20/14 with the Maintenance Director and Assistant Administrator during record review from 9:50 a.m. to 12:15 p.m. on 06/20/14, the natural gas provider letter was signed by the "Commercial Sales Representative" and did not contain a statement regarding the reliability of natural gas delivery and the probability of interruption. 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 and Assistant Administrator during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/20/14, the fuel source for the emergency generator was confirmed to be natural gas.</p> <p>3.1-19(b)</p>			

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K010147 SS=E	<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 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 20 residents, staff and visitors in the vicinity of the North Nurses Station.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Assistant Administrator during a tour of the facility from 1:00 p.m. to 4:15 p.m. on 06/20/14, the following was noted:</p> <p>a. a refrigerator was plugged into a power strip in the Med Select Room near the North Nurses Station.</p> <p>b. a microwave oven was plugged into a power strip in the Nutrition Pantry at the North Nurses Station.</p> <p>Based on interview at the time of the observations, the Maintenance Director</p>	K010147	<ol style="list-style-type: none"> The power strips on the refrigerator in the med select room and on the microwave oven in the North nurses pantry were removed. The microwave was located closer to the power outlet. A new power supply was installed for the med select unit. Residents on E hall, staff, and visitors had the potential to be affected by this alleged deficient practice. The power strips on the refrigerator in the med select room and on the microwave oven in the North nurses pantry were removed. The microwave was located closer to the power outlet. A new power supply was installed for the med select unit. All staff will be inserviced at next scheduled monthly mandatory inservice to discuss use of power strips. All areas were inspected to ensure that power strips are not being used as a substitute for fixed wiring. Any new microwaves or med select units installed will be inspected by the maintenance supervisor/ designee to ensure they are installed properly. Facility maintenance director 	07/09/2014
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	acknowledged power strips were being used as a substitute for fixed wiring at the aforementioned locations. 3.1-19(b)		will audit weekly for 4 weeks, and then monthly for 5 months to ensure that any new med select units or microwaves have been installed properly. Results of audits will be taken to facility monthly CQI meeting for review 5. Maintenance director/ designee is responsible. Completion date 7/9/14.		