

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155029	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/16/2013
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NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218
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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: 09/16/13</p> <p>Facility Number: 000012 Provider Number: 155029 AIM Number: 100274900</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Community Nursing and Rehabilitation Center 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 was determined to be of Type II (111) 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</p>	K010000	Please accept this 2567 Plan of Correction for the Life Safety Survey ending September 16th, 2013 as the Provider's Letter of Credible Allegation. The Plan of Correction completion date will be Wednesday, October 2nd, 2013.	
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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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	<p>smoke detectors installed in resident sleeping rooms 131, 134 through 141 and 234 through 237. The facility has smoke detectors hard wired to the fire alarm system installed in all other resident sleeping rooms. The facility has a capacity of 115 and had a census of 104 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which are each not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/23/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 SS=E	<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. Based on observation and interview, the facility failed to ensure 2 of over 75 corridor doors resisted the passage of smoke. This deficient practice could affect 16 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 11:10 a.m. to 3:05 p.m. on 09/16/13, the corridor door to the Central Supply room on the second floor and the door to the Linen Room on the first floor each had a one quarter inch in diameter hole in the door above the door handle. Based on interview at the time of observation, the Maintenance Supervisor</p>	K010018	<p>K018 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The alleged deficient practice has the potential to affect 16 residents, staff and visitors. The one quarter inch hole found in 2 of 75 doors will be repaired by filling with fire retardant silicone. This will make the doors smoke resistant as per code. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The alleged deficient practice has the potential to affect 16 residents, staff and visitors. The one quarter inch hole found in 2 of 75 doors will be repaired by filling with fire retardant silicone. This will make the doors smoke resistant as per code. What</p>	10/02/2013			

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	and the Maintenance Assistant acknowledged each of the aforementioned corridor doors was not smoke resistant. 3.1-19(b)		measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? All doors within facility that are required to be smoke resistant will be audited to ensure there are no other holes in the doors that would hinder them from being smoke resistant. When door handles/fixtures are changed, Maintenance Director will ensure fixtures are installed appropriately to maintain smoke barrier. 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? During monthly environmental rounds, Maintenance Director or designee will inspect all doors and will report any deficiencies found to monthly QAA committee for review and ensure corrective action takes place immediately.		

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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 ensure 2 of 2 ceiling smoke barriers were maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 52 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 11:10 a.m. to 3:05 p.m. on 09/16/13, the following openings in the ceiling smoke barrier on the first and second floor were noted:</p> <p>a. the two inch annular space surrounding a one inch in diameter sprinkler pipe penetrating the ceiling in the closet of Room 212.</p> <p>b. a two inch in diameter hole in the ceiling of the bathroom in the Conference</p>	K010025	<p>K025 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? This alleged deficient practice has the potential to affect 52 residents, staff and visitors. Space found around sprinkler pipe will be filled with fire retardant silicone to ensure smoke barrier in placeTwo inch hole in ceiling will be patched with sheet rock and mud to ensure smoke barrier in placeNew ceiling tile will be added to cover two foot by eighteen inch section to ensure smoke barrier in placeTwo, one inch in diameter holes in Laundry room ceiling will be patched with sheet rock and mud to ensure smoke barrier in placeCeiling tile will be added to twelve by six inch hole in ceiling of the mechanical room and fire retardant silicone will be added around the edges to ensure smoke barrier in place This alleged deficient practice could</p>	10/02/2013			

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	<p>Room on the first floor.</p> <p>c. a two foot by eighteen inch section of ceiling tile was missing in the first floor storage room across from the Therapy room which exposed the floor deck of the second story.</p> <p>d. two, one inch in diameter holes in the Laundry room ceiling above the washing machines.</p> <p>e. a twelve inch by six inch hole in the ceiling of the mechanical room by Room 129.</p> <p>Based on interview at the time of the observations, the Maintenance Supervisor and the Maintenance Assistant acknowledged the aforementioned openings in the ceiling smoke barriers on the first and second floor did not provide at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure openings through 1 of 4 smoke barrier walls on the second floor were protected to maintain the smoke resistance of the smoke barrier. This deficient practice could affect 42 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the</p>		<p>affect 42 residents, staff and visitors. The two inch annular space surrounding a four inch in diameter pipe passing through the smoke barrier wall above the ceiling by the corridor smoke barrier doors will be filled with fire retardant silicone to ensure and maintain smoke resistance in the smoke barrier How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All pipes that intrude through brick wall above fire doors in facility will be inspected to ensure there are no openings that would compromise the smoke resistance of the smoke barrier. If any holes found, the same above mentioned corrective action will take place. This alleged deficient practice has the potential to affect 52 residents, staff and visitors. Space found around sprinkler pipe will be filled with fire retardant silicone to ensure smoke barrier in place Two inch hole in ceiling will be patched with sheet rock and mud to ensure smoke barrier in place New ceiling tile will be added to cover two foot by eighteen inch section to ensure smoke barrier in place Two, one inch in diameter holes in Laundry room ceiling will be patched with sheet rock and mud to ensure smoke barrier in place Ceiling tile will be added to twelve by six inch hole in ceiling of the mechanical</p>				

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	<p>Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 11:10 a.m. to 3:05 p.m. on 09/16/13, the two inch annular space surrounding a four inch in diameter pipe passing through the smoke barrier wall above the ceiling by the corridor smoke barrier doors by Room 236 was not smoke resistant. In addition, the aforementioned four inch in diameter pipe through which twenty electrical cables passed was not smoke resistant. Based on interview at the time of observation, the Maintenance Supervisor and the Maintenance Assistant acknowledged the aforementioned openings in the smoke barrier wall above the ceiling by Room 236 failed to maintain the smoke resistance of the smoke barrier.</p> <p>3.1-19(b)</p>		<p>room and fire retardant silicone will be added around the edges to ensure smoke barrier in place This alleged deficient practice could affect 42 residents, staff and visitors. The two inch annular space surrounding a four inch in diameter pipe passing through the smoke barrier wall above the ceiling by the corridor smoke barrier doors will be filled with fire retardant silicone to ensure and maintain smoke resistance in the smoke barrier What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? All pipes that intrude through brick wall above fire doors in facility will be inspected to ensure there are no openings that would compromise the smoke resistance of the smoke barrier. If any holes found, the same above mentioned corrective action will take place.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? During monthly environmental rounds, Maintenance Director or designee will check the integrity of ceiling tiles and walls where pipes protrude and report any deficiencies found to monthly QAA committee for review and ensure corrective action takes place immediately.</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 1 of 10 hazardous areas such as laundries was separated from other spaces by smoke resistant partitions and doors. This deficient practice could affect 5 staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 11:10 a.m. to 3:05 p.m. on 09/16/13, there were two holes one inch in diameter in the Laundry room ceiling above the washing machines. Based on interview at the time of observation, the Maintenance Supervisor and the Maintenance Assistant acknowledged the aforementioned openings in the ceiling smoke barrier in the Laundry room failed to separate the</p>	K010029	<p>K029 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The alleged deficient practice has the potential to affect 5 staff and visitors. The two holes, one inch in diameter will be filled with fire retardant silicone and covered with sheet rock and mud to effectively separate the area from other spaces by smoke resistant partitions. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The alleged deficient practice has the potential to affect 5 staff and visitors. The two holes, one inch in diameter will be filled with fire retardant silicone and covered with sheet rock and mud to effectively separate the area from other spaces by smoke resistant partitions. Visual inspection will be conducted by Maintenance</p>	10/02/2013
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	area from other spaces by smoke resistant partitions. 3.1-19(b)		Director or designee of all ceilings in hazardous areas to ensure complete separation from other spaces by smoke resistant partitions and doors. If any deficiencies are found, corrective action will be immediately taken as described above. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Visual inspection will be conducted by Maintenance Director or designee of all ceilings in hazardous areas to ensure complete separation from other spaces by smoke resistant partitions and doors. If any deficiencies are found, corrective action will be immediately taken as described above. 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? During monthly environmental rounds, Maintenance Director or designee will report any deficiencies found in hazardous areas to monthly QAA committee for review and ensure corrective action takes place immediately.	

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure the means of egress through 3 of 8 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 means only. Exception: Where approved by the authority having jurisdiction, a</p>	K010038	<p>K038What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? This alleged deficient practice could affect 60 residents, staff or visitors wanting to exit the facility using the Main Entrance, the Main Dining Room exit on the first floor and the Ambulance exit by the service cooridor. Signage will be placed on each of the above mentioned doors that states the door can be opened after pushing on it for 15 seconds This alleged deficient practice could affect 8 residents, staff and visitors. The code to release the maglock will be posted at the north stairwell exit door to the exit discharge allowing anyone to immediately access the outside How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? This alleged deficient practice could affect 60 residents, staff or visitors wanting to exit the facility using the Main Entrance, the Main Dining Room exit on the first floor and the Ambulance exit by the service cooridor. Signage will be placed on each of the above mentioned doors that states the door can be opened</p>	10/02/2013
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	<p>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 60 residents, staff or visitors wanting to exit the facility using the Main Entrance, the Main Dining Room exit on the first floor and the Ambulance exit by the service corridor.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 11:10 a.m. to 3:05 p.m. on 09/16/13, the Main Entrance, the Main Dining Room exit on the first floor and the Ambulance exit by the service corridor are each provided with a delayed egress lock on the door but were not provided with signage stating the door could be opened after pushing on the door. In addition, each of the aforementioned exit doors were magnetically locked and could be opened by entering a four digit code, but the code</p>		<p>after pushing on it for 15 seconds This alleged deficient practice could affect 8 residents, staff and visitors. The code to release the maglock will be posted at the north stairwell exit door to the exit discharge allowing anyone to immediately access the outside There are two other stairwell exits that exist in facility that have two doors as a means of egress. Both areas will be inspected to ensure there are no more than one consecutive door in the path of egress with a lock in place. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? There are two other stairwell exits that exist in facility that have two doors as a means of egress. Both areas will be inspected to ensure there are no more than one consecutive door in the path of egress with a lock in place. 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? During monthly environmental rounds, Maintenance Director or designee will visualize exit doors to ensure signage in place and report any deficiencies found to monthly QAA committee for review and ensure corrective action takes place immediately.</p>				

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	<p>was not posted at the exit. Each of the aforementioned exit doors released in 15 seconds by pushing on the door release device. Based on interview at the time of the observations, the Maintenance Supervisor and the Maintenance Assistant acknowledged each of the aforementioned exit doors was not provided with 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>2. Based on observation and interview, the facility failed to ensure not more than one delayed egress lock device was provided in any egress path as permitted by NFPA 101 19.2.2.2.4 Exception No. 2 in 1 of 8 egress paths. 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 8 residents, staff and visitors.</p>			

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	<p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 11:10 a.m. to 3:05 p.m. on 09/16/13, the egress path through the north stairwell was provided with two delayed egress locks. The second floor north stairwell door by Room 237 and the north stairwell exit door to the exit discharge were each provided with a delayed egress lock device. Based on interview at the time of the observations, the Maintenance Supervisor and the Maintenance Assistant acknowledged there is more than one delayed egress lock device in the north stairwell path of egress.</p> <p>3.1-19(b)</p>			
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K010050 SS=F	<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</p> <p>Based on record review and interview, the facility failed to document fire drills conducted on the third shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Supervisor and the Maintenance Assistant during record review from 9:05 a.m. to 11:10 a.m. on 09/16/13, documentation of a fire drill conducted on the third shift for the fourth quarter of 2012 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged documentation of a fire drill conducted on the third shift for the fourth quarter of 2012 was not available for review.</p>	K010050	<p>K050What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The alleged deficient practice has the potential to affect all residents, staff and visitors. A fire drill will be conducted on third shift by October 2nd, 2013. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The alleged deficient practice has the potential to affect all residents, staff and visitors. A fire drill will be conducted on third shift by October 2nd, 2013. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Fire drills will be held at unexpected times under varying conditions, at least quarterly on each shift by the Maintenance Director or designee. Maintenance Director or designee will report and record monthly in Safety Committee</p>	10/02/2013	

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	3.1-19(b)		meeting when past month fire drill was held (i.e. what time and on what shift) to ensure all three shifts have been drilled once quarterly.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? Maintenance Director or designee will report and record monthly in Safety Committee meeting when past month fire drill was held (i.e. what time and on what shift) to ensure all three shifts have been drilled once quarterly.Maintenance Director or designee will report any deficiencies found to monthly QAA committee for review and ensure corrective action takes place immediately.	

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K010056 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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 the sprinkler system was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. These deficient practices could affect five staff or visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 11:10 a.m. to 3:05 p.m.</p>	K010056	<p>K056What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? This alleged deficient practice has the potential to affect 5 staff or any visitors in the kitchen. A hanger will be attached to support the 32 inch length of the sprinkler pipe protruding from the wall above the door in the kitchen pantry to ensure no more than 24 inches is unsupported. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? This alleged deficient practice has the potential to affect 5 staff or any visitors in the kitchen. A hanger will be attached to support the 32 inch length of the sprinkler pipe protruding from the wall above the door in the kitchen pantry to ensure no more</p>	10/02/2013

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	<p>on 09/16/13, a 32 inch horizontal length of steel sprinkler pipe protruding from the wall above the door in the kitchen pantry was unsupported. A dangling bracket on the aforementioned sprinkler pipe did not have a hanger attached to support the 32 inch length of the sprinkler pipe. Based on interview at the time of observation, the Maintenance Supervisor and the Maintenance Assistant acknowledged the aforementioned sprinkler pipe was an unsupported armover greater than 24 inches in length for a steel pipe.</p> <p>3.1-19(b)</p>		<p>than 24 inches is unsupported. House wide audit will be performed of all exposed sprinkler pipe to ensure that if hanging and protruding from wall, will not have more than 24 inches of pipe unsupported. If any deficiencies found, corrective action will take place immediately. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? House wide audit will be performed of all exposed sprinkler pipe to ensure that if hanging and protruding from wall, will not have more than 24 inches of pipe unsupported. If any deficiencies found, corrective action will take place immediately. 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? During routine environmental rounds, Maintenance Director or designee will report any deficiencies found to monthly QAA committee for review and ensure corrective action takes place immediately.</p>	

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K010069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure 1 of 1 kitchen exhaust system baffles were installed correctly. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 3-2.5 states filters shall be installed at an angle not less than 45 degrees from the horizontal. This deficient practice could affect five staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 11:10 a.m. to 3:05 p.m. on 09/16/13, three of six baffles in the kitchen range hood are aligned horizontally in the kitchen range hood exhaust system. Based on interview at the time of observation, the Maintenance Supervisor and the Maintenance Assistant acknowledged three of six baffles in the kitchen range exhaust hood are aligned horizontally and would not drain grease properly in the present configuration.</p> <p>3.1-19(b)</p>	K010069	<p>K069What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? This alleged deficient practice has the potential to affect 5 staff and any visitors in the kitchen. In order to drain grease properly, three of the six baffles in the kitchen range hood that are aligned horizontally will be realigned to drain vertically, not less than 45 degrees from the horizontal. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? This alleged deficient practice has the potential to affect 5 staff and any visitors in the kitchen. In order to drain grease properly, three of the six baffles in the kitchen range hood that are aligned horizontally will be realigned to drain vertically, not less than 45 degrees from the horizontal. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Certified contractor conducts exhaust hood cleaning and certification on a semi-annual basis. Maintenance Director or designee will inspect baffles status post vendor visit to ensure baffles are aligned properly after</p>	10/02/2013

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			exhaust hood cleaning.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? During monthly environmental rounds, Maintenance Director or designee will report any deficiencies found to monthly QAA committee for review and ensure corrective action takes place immediately.	

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K010072 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 means of egress on the first floor was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 25 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 11:10 a.m. to 3:05 p.m. on 09/16/13, the exit discharge for the corridor exit by Room 115 is into the outdoor smoking area. The corridor exit by Room 115 is marked as a facility exit. One chair in the outdoor smoking area was placed up against the exit door and two additional chairs of the outdoor smoking area obstructed the path to the public way. Based on interview at the time of observation, the Maintenance Supervisor and the Maintenance Assistant acknowledged the exit discharge for the</p>	K010072	<p>K072What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? This alleged deficient practice has the potential to affect 25 residents, staff and visitors. All obstructions and/or impediments will be removed from the exit door to ensure that the path to the public way is not obstructed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? This alleged deficient practice has the potential to affect 25 residents, staff and visitors. All obstructions and/or impediments will be removed from the exit door to ensure that the path to the public way is not obstructed. House wide audit will be performed with visual inspection of the exterior of all exit doors to building to ensure all are free from obstructions and/or impediments to allow immediate access to the public way in the event of an emergency. What measures will be put into place or what systemic changes will you</p>	10/02/2013			

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	<p>the corridor exit by Room 115 was into the outdoor smoking area and was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>3.1-19(b)</p>		<p>make to ensure that the deficient practice does not recur? Staff will be in-serviced by Staff Development Coordinator or designee by October 2nd, 2013 on keeping the exit door free from obstructions and/or impediments to allow immediate access to the public way in the event of an emergency. House wide audit will be performed with visual inspection of the exterior of all exit doors to building to ensure all are free from obstructions and/or impediments to allow immediate access to the public way in the event of an emergency. 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? During monthly environmental rounds, Maintenance Director or designee will visually inspect exit doors and corridors and report any deficiencies found to monthly QAA committee for review and ensure corrective action takes place immediately.</p>		

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review, observation and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 25 residents, staff and visitors in the Main Dining Room on the first floor.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor and the Maintenance Assistant during record review from 9:05 a.m. to 11:10 a.m. on</p>	K010130	<p>K130What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? This alleged deficient practice has the potential to affect 25 residents, staff and visitors in the Main Dining Room of the first floor. Certified vendor will complete inspection and testing for proper operation and full closure by Wednesday, October 2nd, 2013. Report will be kept on file. Any deficiencies noted on inspection will be corrected immediately This alleged deficient practice has the potential to affect 32 residents, staff and visitors on the first and second floor. New batteries will be installed in all smoke detectors in the 16 rooms identified to be allegedly deficient in having documentation of battery replacement within the last 12 months. Log will be updated in Preventive Maintenance binder with new battery replacement date Battery operated smoke detectors found in rooms 110, 115, 130 and 131 will be removed due to each room already having a smoke detector hard wired to the fire alarm system. Code does not require both detectors in each room. Preventive Maintenance Log will be updated accordingly How will you identify other residents having the potential to be affected</p>	10/02/2013

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	<p>09/16/13, documentation of rolling fire door annual inspection and testing for proper operation and full closure was not available for review. Based on observation with the Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 11:10 a.m. to 3:05 p.m. on 09/16/13, there is a rolling fire door protecting the opening from the kitchen to the Main Dining Room on the first floor. The attached inspection tag "Annual Fire Door & Drop Test Record" to the rolling fire door from Overhead Door stated an annual inspection and test was performed on 05/31/11. Based on interview at the time of observation, the Maintenance Supervisor and the Maintenance Assistant stated no additional annual inspection and testing documentation was available for review and acknowledged it has been more than one year since the most recent annual inspection and test of the aforementioned rolling fire door.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 16 of 58 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the</p>		<p>by the same deficient practice and what corrective action will be taken? This alleged deficient practice has the potential to affect 25 residents, staff and visitors in the Main Dining Room of the first floor. Certified vendor will complete inspection and testing for proper operation and full closure by Wednesday, October 2nd, 2013. Report will be kept on file. Any deficiencies noted on inspection will be corrected immediately This alleged deficient practice has the potential to affect 32 residents, staff and visitors on the first and second floor. New batteries will be installed in all smoke detectors in the 16 rooms identified to be allegedly deficient in having documentation of battery replacement within the last 12 months. Log will be updated in Preventive Maintenance binder with new battery replacement date Battery operated smoke detectors found in rooms 110, 115, 130 and 131 will be removed due to each room already having a smoke detector hard wired to the fire alarm system. Code does not require both detectors in each room. Preventive Maintenance Log will be updated accordingly What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Maintenance Director or designee will ensure Certified Vendor is contracted to inspect rolling door</p>		

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	<p>public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect 32 residents, staff and visitors in on the first and second floor.</p> <p>Findings include:</p> <p>a. Based on review of "Battery Operated Smoke Detector Maintenance Log for Year 2012 and 2013" documentation with the Maintenance Supervisor and the Maintenance Assistant during record review from 9:05 a.m. to 11:10 a.m. on 09/16/13, the itemized listing of the results of monthly battery operated smoke detector testing resident sleeping rooms 134 through 141 and 234 through 237 for the period 06/30/12 through 09/03/13 did not include information in regard to battery replacement. Based on observations with the Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 11:10 a.m. to 3:05 p.m. on 09/16/13, battery operated smoke detectors were observed installed in resident sleeping rooms 134 through 141, 234 through 237 and in Room 110, 115, 130 and 131. Each of the aforementioned smoke detectors were powered by a nine volt battery. Based on interview at the time of observation, the Maintenance Supervisor and the Maintenance Assistant stated batteries in</p>		<p>annually.Preventive Maintenance log will be reviewed monthly to ensure all smoke detector inspections have been logged as well as battery replacement reviewed and logged appropriately. Any deficiencies found will be immediately corrected and noted in monthly Safety Committee meeting.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? During monthly environmental rounds, Maintenance Director or designee will report any deficiencies found to monthly QAA committee for review and ensure corrective action takes place immediately.</p>				

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	<p>the aforementioned resident sleeping room smoke detectors have not been replaced since 06/30/12 and acknowledged documentation of annual battery operated smoke detector battery replacement was not available for review.</p> <p>b. Based on observations with the Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 11:10 a.m. to 3:05 p.m. on 09/16/13, resident sleeping rooms 110, 115 and 130 each had a smoke detector hard wired to the fire alarm system and a battery operated smoke detector installed in the room. Resident sleeping Room 131 had two battery operated smoke detectors installed in the room. The aforementioned battery operated smoke detectors were each powered by a nine volt battery. Based on review of "Battery Operated Smoke Detector Maintenance Log for Year 2012 and 2013" documentation with the Maintenance Supervisor and the Maintenance Assistant during record review from 9:05 a.m. to 11:10 a.m. on 09/16/13, an itemized listing of the results of monthly battery operated smoke detector testing and annual battery replacement for resident sleeping rooms 110, 115, 130 and 131 was not available for review. Based on interview at the time of observation and record review, the Maintenance Supervisor and Maintenance Assistant</p>			

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	<p>stated he was unaware battery operated smoke detectors were installed in the aforementioned resident sleeping rooms and acknowledged documentation of monthly battery operated smoke detector testing and annual battery replacement was not available for review.</p> <p>3.1-19(a)</p>			

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K010144 SS=F	<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 and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 6 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available to the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator-Weekly Exercise/Monthly Load Test Log" documentation with the Maintenance Supervisor and the Maintenance Assistant during record review from 9:05 a.m. to 11:10 a.m. on 09/16/13, load test documentation for emergency power transfer time for the six</p>	K010144	<p>K144What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? This alleged deficient practice has the potential to affect all residents, staff and visitors. Generator load tests are set up by certified vendor to automatically test at the same time on the same day each week. Maintenance Director will observe test weekly and record the emergency power transfer time in seconds. If the load transfer time is longer than 10 seconds, certified vendor will immediately be contacted to inspect and correct any deficiencies. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? This alleged deficient practice has the potential to affect all residents, staff and visitors. Generator load tests are set up by certified vendor to automatically test at the same time on the same day each week. Maintenance Director will observe test weekly and record the emergency power transfer time in seconds. If the load transfer time is longer than 10</p>	10/02/2013

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	<p>month period of January 2013 through June 2013 is recorded as the time of day. Based on interview at the time of record review, the Maintenance Supervisor acknowledged emergency power transfer time documentation for the aforementioned load tests was recorded as the time of day.</p> <p>3.1-19(b)</p>		<p>seconds, certified vendor will immediately be contacted to inspect and correct any deficiencies. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Generator Preventive Maintenance test and inspection log will be reviewed by Maintenance Director or designee monthly. Executive Director will review and sign off for accuracy and completion monthly. Any deficiencies found and corrected by certified vendor will be reviewed in monthly Safety Committee meeting. 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? During weekly/monthly test and inspections, Maintenance Director or designee will report any deficiencies found to monthly QAA committee for review and ensure corrective action takes place immediately.</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 3 of 3 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 8 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 11:10 a.m. to 3:05 p.m. on 09/16/13, the following was noted:</p> <p>a. a fan was plugged into an extension cord which was plugged into a power strip in the Health Information Management Office on the second floor.</p> <p>b. a fan was plugged into an extension cord in the Sprinkler Riser Room on the first floor.</p> <p>c. a microwave oven was plugged into a power strip in the Staff Development Coordinator's Office on the first floor.</p> <p>Based on interview at the time of the observations, the Maintenance Supervisor</p>	K010147	<p>K147What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? This alleged deficient practice has the potential to affect 8 residents, staff and visitors. Extension cord will be removed from Health Information Management office on the second floorExtension cord will be removed from the Sprinkler Riser Room on the first floorMicrowave oven was unplugged from the power strip and plugged directly into the wall in the Staff Development Coordinator's office on the first floor How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? This alleged deficient practice has the potential to affect 8 residents, staff and visitors. Extension cord will be removed from Health Information Management office on the second floorExtension cord will be removed from the Sprinkler Riser Room on the first floorMicrowave oven was unplugged from the power strip and plugged directly into the wall in the Staff Development Coordinator's office on the first floorHouse wide audit will be performed by Customer Care</p>	10/02/2013			

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	and the Maintenance Assistant acknowledged the aforementioned locations were using extension cords including power strips as a substitute for fixed wiring. 3.1-19(b)		Representatives or designee to ensure no extension cords are in use and if power strips are in use that no high voltage items or medical equipment are plugged into the power strip. Any extension cords found will be permanently removed. Any high voltage items or medical equipment found plugged into power strips will be unplugged from power strip and plugged directly into wall socket. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? House wide audit will be performed by Customer Care Representatives or designee to ensure no extension cords are in use and if power strips are in use that no high voltage items or medical equipment are plugged into the power strip. Any extension cords found will be permanently removed. Any high voltage items or medical equipment found plugged into power strips will be unplugged from power strip and plugged directly into wall socket. 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? During monthly environmental rounds, Customer Care Representatives or designee will report any deficiencies found to monthly QAA committee for review and ensure corrective	

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			action takes place immediately.	

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K010160 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observation and interview, the facility failed to ensure the elevator equipment in 1 of 1 elevator equipment rooms was provided with a shunt trip. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect five residents, staff and visitors in the elevator if the sprinkler system was activated in the elevator machine room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 11:10 a.m. to 3:05 p.m. on 09/16/13, the elevator machine room in the Boiler Room is provided with automatic sprinklers and evidence of shunt trip installation was not noted.</p>	K010160	<p>K160What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? This alleged deficient practice has the potential to affect 5 residents, staff and visitors in the elevator if the sprinkler system was activated in the elevator machine room. Shunt trip installation will be completed by October 2nd, 2013 in the elevator machine room to ensure there is a means for immediately disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? This alleged deficient practice has the potential to affect 5 residents, staff and visitors in the elevator if the sprinkler system was activated in the elevator machine room. Shunt trip installation will be completed by licensed contractor by October 2nd, 2013 in the elevator machine</p>	10/02/2013

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	<p>Based on interview at the time of observation, the Maintenance Supervisor and the Maintenance Assistant stated a quote for shunt trip installation has been procured, comprehensive care residents have customary access to the elevator and acknowledged the aforementioned elevator machine room was not provided with a shunt trip.</p> <p>3.1-19(b)</p>		<p>room to ensure there is a means for immediately disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Copy of completed installation procedure and instructions will be kept on file. There is only one elevator in facility and elevator shunt trip device is permanently affixed. 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? Maintenance Director or designee will review internal Life Safety binder which holds all annual, semi-annual and quarterly safety inspections to ensure compliance annually. Any deficiencies noted will be reviewed in QAA committee meeting.</p>	