

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/10/2014
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NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835
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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: 06/10/14</p> <p>Facility Number: 000275 Provider Number: 155656 AIM Number: 100290930</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Canterbury 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 one story facility with an attached two story wing was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors</p>	K010000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set for the statement of deficiencies. The plan of correction is prepared and/or soley executed because it is required by the provisions of federal and state law.	
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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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K010029 SS=E	<p>and battery operated smoke detectors in all resident rooms. The facility has a capacity of 147 and had a census of 121 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility had a detached garage providing facility services including the emergency generator room, storage of the mower, maintenance equipment and supplies that was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/17/14.</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 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</p>			

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	<p>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 the corridor door to hazardous areas such as 1 of 1 resident room storage rooms with combustibles, measuring over 50 square feet in size, 1 of 1 shower rooms on the 300 hall and 1 of 1 kitchens were provided with a self closing device, and latched into the frame. This deficient practice could affect 3 of 9 smoke compartments.</p> <p>Findings include:</p> <p>a. Based on an observation with the Maintenance Director on 06/10/14 at 1:35 p.m., the corridor door to resident room 551, measuring 220 square feet, full of cardboard boxes with resident records and administrative paperwork lacked a self closing device. The room measurements were provided by the Maintenance Director at the time of observation.</p> <p>b. Based on an observation with the Maintenance Director on 06/10/14 at 2:35 p.m., the corridor door to the 300 hall shower room did self close but failed to latch into the door frame. The shower room had one barrel of soiled linen and one barrel of trash stored in the room. The Maintenance Director confirm the</p>	K010029	<p>K 029</p> <p>It is the policy of this facility to provide one hour fire rated construction doors in accordance with 8.4.1 and/or 19.3.5.4, which protects hazardous areas.</p> <p>Corrective action for alleged deficient practice:</p> <p>a) Self closing device applied to the door to room 551.</p> <p>b) Soiled linen barrel and trash can has been relocated from the 300 shower room. Shower door adjusted to ensure that the door latches into the frame without delay.</p> <p>c) Door to the dishwashing room was closed and dietary staff were in-serviced on not propping the door open.</p> <p>Identification of others with potential to be affected by alleged deficient practice:</p> <p>A check of all 1 hour fire rated doors was completed to assure they close and latch properly.</p> <p>Systematic changes in place for alleged deficient practice:</p> <p>Life environmental director was trained on this regulation.</p> <p>How corrective action will be monitored to ensure alleged deficient practice does not recur:</p> <p>Life Environmental Director will complete wklly audit of 1 hour fire</p>	07/10/2014

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K010038 SS=E	<p>shower door did not latch into the frame because it was rubbing against the door frame at the top of the door.</p> <p>c. Based on an observation and interview with the Maintenance Director on 06/10/14 at 2:40 p.m., he acknowledged the door entering the dishwashing area of the kitchen was propped open with a wedge.</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>Based on observation and interview, the facility failed to ensure 1 of 2 exit doors from the main dining room was accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires 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 not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15</p>	K010038	<p>rated doors to assure they close and latch properly. Asst. Administrator will review audits during wkly meeting with the LED for 4 weeks. Administrator will review results of the audits for 3 months during the facility CQI process. Any issues will be corrected.</p> <p>It is the practice of this facility that exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1 19.2.1</p> <p>Corrective action for alleged deficient practice: A 15 second sign was placed on the exit door leading to the service corridor from the main dining room that reads: "Push until alarm sounds door can be opened in 15 seconds."</p> <p>Identification of others with potential to be affected by alleged deficient practice: One time facility audit of all exit doors to ensure appropriate signage</p>	07/10/2014

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K010039 SS=E	<p>SECONDS." This deficient practice could affect at least 27 residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 06/10/14 at 2:45 p.m., the exit door leading to the service corridor from the main dining room was equipped with a electromagnetic lock that released after pushing the door for 15 seconds, but it lacked the proper sign. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-15(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 exit access corridors from the main dining room had a clear and unobstructed exit width of at least 4 feet (48 inches). This deficient practice could affect at least 27 residents evacuated through the service hall from the main dining room in the event of an</p>	K010039	<p>is present.</p> <p>Systematic changes in place for alleged deficient practice: The Environmental Director daily rounds check list will be updated to include sign-off that confirms that correct signage is present for all exit doors with delayed e-gress.</p> <p>How corrective action will be monitored to ensure alleged deficient practice does not recur: The Environmental Director will be responsible to monitor on a wklly basis. The Asst. Administrator will meet once a wk. with the Environmental Director to review results of the rounds. The administrator will review outcomes once/monthly for 3 months during facility CQPI meetings. Any non-compliance issues will be addressed with the CQPI committee for further recommendations.</p> <p>It is the practice of the facility to ensure exit access corridors are clear and unobstructed. Corrective action for alleged deficient practice: a) Coolers were removed from the corridor and relocated to a area that does not cause obstruction. b) Sign placed to alert staff where to store the coolers without causing obstruction in the exit corridor.</p>	07/10/2014			

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	<p>emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 06/10/14 at 2:50 p.m., there were two plastic coolers stored in the corridor of the service hall decreasing the clear width of the corridor to 36 inches. Measurements were provided by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>		<p>Dietary Staff in-serviced to new location Identification of others with potential to be affected by alleged deficient practice: One time facility audit of all corridors that are identified as exits completed to ensure that they are clear and unobstructed. Systematic changes in place for alleged deficient practice: The Environmental Director daily rounds check list will be updated to include corridor checks 5 times a week time four weeks to ensure that all exit corridors are clear and unobstructed. How corrective action will be monitored to ensure alleged deficient practice does not recur: The Environmental Director will be responsible to ensure that checks are completed 5 times a week his department. The Asst. Administrator will meet once a week for 4 weeks with the ED to review maintenance check log. The administrator will review the maintenance check log once a month for 3 months during facility CQPI. Any non-compliance will be addressed during the CQPI committee for further recommendations and/or educational opportunities.</p>		
K010044 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 8 fire door sets was arranged to automatically close</p>	K010044	<p>It is the practice of this facility to ensure that fire doors automatically close and latch.</p>	07/10/2014	

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K010050 SS=C	<p>and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect residents in 2 of 9 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 06/10/1 at 4:00 p.m., the fire door set near resident room 545 failed to latch into the frame. This was acknowledged by the Maintenance Director at the time of observation, who confirmed these were fire doors.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for</p>		<p>Corrective action for alleged deficient practice: The fire door set near rm 545 was adjusted to latch into the frame. Identification of others with potential to be affected by alleged deficient practice: All fire doors audited to ensure that they latch into the frame upon release. Systematic changes in place for alleged deficient practice: Door checks will be implemented 5 times a wk time four weeks. by the maintenance department to ensure that they latch into frames upon release. How corrective action will be monitored to ensure alleged deficient practice does not recur: Environmental Director will review checks with his department to ensure that all doors are functioning appropriately for 30 days. The Asst. Administrator will meet once a week with the ED to review logs and identify any issues of concern. The Administrator will review monitoring records once a month for 3 months during the CQPI committee and will address any areas of non-compliance through the CQPI committee</p>	

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	<p>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 include the fire drill location and type of fire for 12 of the last 12 calendar months and the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Fire Drill Report" documentation with the Maintenance Director on 06/10/14 from 12:49 p.m. to 12:53 p.m., the fire drill documentation did not include the location of the fire drill and the type of fire simulated. Additionally, all first shift fire drills took place between 9:18 a.m. and 10:35 a.m. This was acknowledged by the Maintenance Director at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p>	K010050	<p>It is the practice of this facility to hold fire drills in accordance with sec 19.7.1.2</p> <p>Corrective action for alleged deficient practice: Maintenance Supervisor was in-serviced regarding fire drill requirements, including correct documentation and times. Identification of others with potential to be affected by alleged deficient practice: All residents have potential to be affected by alleged deficient practice. Systematic changes in place for alleged deficient practice: Environmental Director will develop a 3 month schedule for upcoming fire drills. The Assistant Administrator will review to ensure that fire drills are schedule on all shifts at different times. How corrective action will be monitored to ensure alleged deficient practice does not recur: The Assistant Administrator will review completed fire drill documentation after each drill to ensure that documentation is complete and meets regulation. The administrator will review fire drill logs once a month for 3 months during CQPI and will address any</p>	07/10/2014

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K010052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of Vanguard Alarm Services quarterly fire alarm system inspections titled "Periodic Fire Alarm Inspection and Testing Report" with the Maintenance Director on 06/10/14 at</p>	K010052	<p>non-compliance issues with the CQPI committee. Date of Compliance: 7-10-13</p> <p>It is the practice of this facility to have a fire alarm system installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. Corrective action for alleged deficient practice: Smoke Detectors, Duct Detectors and Heat Detectors were inspected by Vanguard. Identification of others with potential to be affected by alleged deficient practice: A audit of all smoke detectors, duct detectors and heat detectors was completed and areas identified were corrected. Systematic changes in place for alleged deficient practice: Environmental Director was educated on the regulation of fire alarm system inspections. Annual Fire Alarm System inspections have been scheduled automatically with the facility's fire alarm monitoring company. How corrective action will be monitored to ensure alleged deficient practice does not recur: The Asst. Administrator will review all</p>	07/10/2014

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K010056 SS=E	<p>12:40 p.m., 67 smoke detectors, 14 duct detectors and seven heat detectors did not receive an annual test for the previous year. This was confirmed by the Maintenance Director at the time of record review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Bistros in the 500 hall was provided with sprinklers with the same temperature classification which operate in a timely manner and achieve effective fire control. NFPA 13, Table 3-2.5.1 rates sprinklers with temperature ratings between 135 and 170 degrees Fahrenheit (F) as Ordinary and sprinklers with temperature ratings between 175 and 225 degrees F as</p>	K010056	<p>inspection reports completed by outside entities on wkly basis with the Environmental Director . The Administrator will review all inspection reports on a monthly basis for 3 months at the CQPI meeting. Any identified areas will be addressed by the CQPI committee.</p> <p>It is the practice of the facility to have an automatic, reliable and adequate water supply for the system including concurrent water temperatures. Corrective action for alleged deficient practice: Two of the eight sprinkler heads will be replaced to replicate the specifications of the red liquid filled ordinary rated sprinkler heads</p>	07/10/2014			

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K010062 SS=D	<p>Intermediate. NFPA 13, 1999 Edition, Standard for the Installation of Sprinkler Systems, 5-1.1 requires spacing, location, and position of sprinklers shall be based on the following principles: (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. This deficient practice could affect approximately 10 resident in the 500 hall Bistro.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 06/10/14 at 3:35 p.m., two of the eight sprinkler heads in the 500 hall Bistro were a green liquid filled Intermediate rated sprinkler head (200 degrees F) and the remaining sprinkler heads were the red liquid filled Ordinary rated sprinkler heads (155 degrees F). This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are</p>		<p>Identification of others with potential to be affected by alleged deficient practice: 100% audit of all sprinkler heads in the facility to ensure compliance with above specifications Systematic changes in place for alleged deficient practice: Educate the environmental director on K056 requirements for sprinkler heads How corrective action will be monitored to ensure alleged deficient practice does not recur: Anytime any remodels or renovations occur the sprinkler heads will be audited by the Environmental Director</p>	

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	<p>continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 reception office closet sprinkler heads was unobstructed. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation and interview with the Maintenance Director on 06/10/14 at 1:58 p.m., he acknowledged the spray pattern of the reception office closet sprinkler head was obstructed by office supplies stacked on the top shelf to within five inches of the sprinkler head.</p> <p>3.1-19(b)</p>	K010062	<p>It is the practice of the facility to have an automatic sprinkler system that is continuously maintained in reliable operating condition and inspected and tested periodically. Corrective action for alleged deficient practice: Closet in receptionist office was cleared from obstruction of the sprinkler head. Identification of others with potential to be affected by alleged deficient practice: One time audit of offices and resident rooms completed. Systematic changes in place for alleged deficient practice: Environmental Director will round 5 times a week to identify and correct any obstruction noticed within the sprinkler heads. All staff educated regarding the regulation. How corrective action will be monitored to ensure alleged deficient practice does not recur: Environmental director will review audit results with the asst. administrator once a week. The administrator will review audit results once a month as part of the facility's CQI process for 3 months. Any non-compliance will be discussed with the CQI committee for further recommendations.</p>	07/10/2014

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K010066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to ensure 1 of 1 areas where smoking was permitted for staff was maintained. This deficient practice could affect at least 27 residents evacuated through the service hall from the main dining room in the event of an emergency.</p> <p>Findings include:</p>	K010066	<p>It is the practice of the facility to maintain smoking areas for residents, family member and staff inclusive of the correct disposal of cigarette butts Corrective action for alleged deficient practice: Staff smoking area was cleared of cigarette butts. Identification of others with potential to be affected by alleged deficient practice:</p>	07/10/2014

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K010130 SS=E	<p>Based on an observation with the Maintenance Director on 06/10/14 at 2:55 p.m., the designated smoking area for facility staff outside at the exit from the service hall was provided with three metal containers with self closing lids. At least forty cigarette butts were observed on the ground in the smoking area. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetrations in 2 of 8 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p>	K010130	<p>A complete facility ground walk was completed and all cigarettes were picked up. Systematic changes in place for alleged deficient practice: Staff educated on appropriate disposal of cigarette butts. Environmental Director will make rounds 5 times a wk to ensure that cigarette butts are picked up and containers are emptied. How corrective action will be monitored to ensure alleged deficient practice does not recur: Smoking Areas will be monitored during administrative rounds once a week for 4 weeks. The administrator will review audit results for 3 months at QPI. Any issues will be addressed.</p> <p>K Tag 130 It is the facilities practice to ensure the penetrations in 2 of 8 fire barrier walls are maintained to ensure the fire resistance of the barrier to maintain and operate to minimize the possibility of a fire emergency.</p> <p>Corrective action for alleged deficient practice: The drop down ceiling at the fire doors entering the 100 hall and 400 hall from the main nurses station the fire wall penetrations will be sealed with fire resistant material consistent with K130 specifications.</p>	07/10/2014

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	<p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect residents in 3 of 9 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 06/10/14 from 4:10 p.m. to 4:15 p.m., above the drop down ceiling at the fire doors entering the 100 hall and the 400 hall from the main nurses' station the fire wall penetrations were sealed with a soft black material. Based on an interview with the</p>		<p>Identification of others with potential to be affected by alleged deficient practice:</p> <p>All firewalls will be inspected for penetrations and to ensure proper sealant is in use.</p> <p>Systematic changes in place for alleged deficient practice:</p> <p>Environmental Director trained on this regulation</p> <p>How corrective action will be monitored to ensure alleged deficient practice does not recur:</p> <p>After any changes have been made to the facility via a utility company, vendor or other construction the Environmental Services Director will audit and inspect all applicable areas one time a week times four weeks. Administrator will monitor compliance through QPI times three months</p> <p>Date of Compliance: 7.10.14</p>	

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K010143 SS=E	<p>Maintenance Director at the time of observations, the black material was plumbing sealant.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 areas used for transferring of oxygen was provided with continuous mechanical ventilation. This deficient practice could affect 1 of 9 smoke compartments.</p> <p>Findings include:</p>	K010143	<p>It is the practice of the facility to transfer oxygen in an area that is mechanically ventilated, sprinkled and has ceramic or concrete flooring</p> <p>Corrective action for alleged deficient practice: Motor in the 400 hall oxygen room fixed. Identification of others with potential to be affected by alleged</p>	07/10/2014

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K010147 SS=D	<p>Based on an observation with the Maintenance Director on 06/10/14 at 2:02 p.m., the mechanical ventilation in the 400 hall oxygen transfilling/storage room which contained at least four large stationary containers of liquid oxygen was not working. This was confirmed by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords was not used as a substitute for fixed wiring to provide power for medical equipment or equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, 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</p>	K010147	<p>deficient practice: Audit of all oxygen rooms completed. No further issues noted. Systematic changes in place for alleged deficient practice: Environmental Director will check Oxygen rooms 5 times a week to make sure mechanical ventilation is working. How corrective action will be monitored to ensure alleged deficient practice does not recur: Environmental Director will maintain audit of room checks 5 time a week. Asst. Administrator will review audit results once a week with ED for 4 weeks. Administrator will review audit results once a month for 3 months during the CQPI process and will address any issues with the CQPI committee for recommendations.</p> <p>Corrective action for alleged deficient practice: Extension cord in room 212 removed. Identification of others with potential to be affected by alleged deficient practice: 1 time facility audit of all rooms completed by maintenance department. Systematic changes in place for alleged deficient practice: Environmental Director will make room rounds 5 times a week times four weeks to ensure that there are no extension cords</p>	07/10/2014

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	<p>practice could affect 2 residents in resident room 212.</p> <p>Findings include:</p> <p>Based on an observation and interview with the Maintenance Director on 06/10/14 at 3:15 p.m., the Maintenance Director acknowledged a refrigerator was supplied electricity by the extension cord power strip laying at the foot of the resident's bed in resident room 212.</p> <p>3.1-19(b)</p>		<p>being used. This regulation will be reviewed with residents during resident council. How corrective action will be monitored to ensure alleged deficient practice does not recur: Environmental Director will review audit results once a week with the assist. Administrator for 4 weeks. The administrator will review audit results once a month for 3 months during the facility CQPI process. Any issues will be discussed with the CQPI committee for further recommendations. Corrective action for alleged deficient practice: Extension cord in room 212 removed. Identification of others with potential to be affected by alleged deficient practice: 1 time facility audit of all rooms completed by maintenance department. Systematic changes in place for alleged deficient practice: Environmental Director will make room rounds 5 times a week to ensure that there are no extension cords being used. This regulation will be reviewed with residents during resident council. How corrective action will be monitored to ensure alleged deficient practice does not recur: Environmental Director will review audit results once a week with the assist. Administrator for 4 weeks. The administrator will review audit results once a month for 3 months during the facility CQPI process. Any issues will be</p>		

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			discussed with the CQPI committee for further recommendations.		