

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155740	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/11/2013
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NAME OF PROVIDER OR SUPPLIER  TIMBERCREST CHURCH OF BRETHREN	STREET ADDRESS, CITY, STATE, ZIP CODE 2201 EAST ST NORTH MANCHESTER, IN 46962
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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: 06/11/13</p> <p>Facility Number: 000448 Provider Number: 155740 AIM Number: 100275140</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist and Robert Sutton, Life Safety Code Specialist Trainee</p> <p>At this Life Safety Code survey, Timbercrest Church of Brethren Home 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) and 410 IAC 16.2. The original building consisting of the 100, 200, 300 and 400 halls was surveyed with Chapter 19, Existing Health Care Occupancies</p> <p>This one story facility with a basement was determined to be of Type V (111) construction and was fully sprinklered.</p>	K010000		

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>The facility has a fire alarm system with hard wired smoke detection in the corridors and areas open to the corridor. Battery operated smoke detectors were installed in the resident rooms. The facility has a capacity of 65 and had a census of 62 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached maintenance garage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/17/13.</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=C	<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 6 of 6 clean linen storage area corridor doors closed and latched into the door frame. This deficient practice includes the clean linen storage areas in all halls therefore it could affect any of the occupants.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance on 06/11/13 from 2:33 p.m. to 2:55 p.m., the clean linen storage areas on the 100, 200, 300 halls and three on the 400 halls were equipped with double corridor doors. One door was equipped with a manual latching device that would latch into the door frame and the remaining door was designed to latch</p>	K010018	The closets in question will be modified with spring closing hinges to keep doors closed when not in use. The inactive door will have an automatic latching bolt to latch the door when the door is closed. The active door would operate as it does latching into the inactive door. Door coordinators will assure that doors close in the proper sequence to assure latching. See attached Exhibit #1 Accepted quote for revision to closet doors.	08/01/2013			

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	<p>into the stationary door. Each door could not latch automatically, and independent of the other door, into the door frame. This was acknowledged by the Director of Maintenance at the time of observations.</p> <p>3.1-19(b)</p>			

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K010038 SS=B	<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 5 exit doors 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 SECONDS". This deficient practice could affect any of the 10 residents on the 300 hall.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 06/11/13 at 1:04 p.m., the double doors entering Crestwood hall were equipped with electromagnetic locks that released after pushing the door for 15 seconds, but a sign about the 15 second delay was not posted. At the time of observation the Director of Maintenance acknowledged, the door entering Crestwood hall lacked a sign with the required verbiage.</p>	K010038	Signs have been posted on the subject doors to meet the requirement.	07/02/2013			

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K010046 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency light fixtures of at least 1½ hour duration was tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. In addition, NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 06/11/13 at 3:15 p.m., a battery operated emergency light was observed at the emergency generator. Based on record review at 11:55 a.m., the last annual ninety minute test on the</p>	K010046	Annual 90 minute test of the emergency light was successfully conducted on June 28, 2013. A recurring work order has been entered into the Maintenance Work Order system to produce an order for the annual test each June. See Exhibits # 2 & #3: Work Order for 90 minute test and Test Log showing test completed on June 28, 2013.	06/28/2013			

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	<p>battery operated light was March of 2012. Based on an interview with the Director of Maintenance at the time of record review, the light had not received an annual test since March of 2012.</p> <p>3.1-19(b)</p>			

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K010061 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 water inlet Outside Screw and Yoke (OS&amp;Y) valves for the sprinkler system were electronically supervised. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 06/11/13 at 12:40 p.m., the water inlet OS&amp;Y valves at the basement sprinkler riser were secured in the open position with a chain and a padlock, however, there was no electronic supervision of the valves. Based on an interview with the Director of Maintenance at the time of observation, the valves have always been chained in the open position.</p> <p>3.1-19(b)</p>	K010061	The required electronic tamper alarms have been ordered to be installed on the OS & Y valves in question.	09/01/2013			

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation and interview, the facility failed to ensure the penetration in 1 of 2 basement fire barrier walls was protected by an approved device designed for the specific purpose and capable of maintaining 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> <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>	K010130	<p><u>K 130</u> 1. The penetration in the basement wall between the resident storage area and the east basement has been sealed. Completion Date: June 29, 2013. See Exhibit # 5, completed Work Order for sealing the penetration in the fire wall between the resident storage area and the east basement.</p> <p>2. On further investigation it was determined that the smoke detectors in the resident rooms on the 300 and 400 halls are wired into the buildings electrical supply system. They are tested monthly for functionality. Fire Protection Service Co., Inc. was contracted to test the sensitivity of all resident room smoke detectors. These will be added to the annual sensitivity testing of smoke detectors done by this company. See Exhibit 11.</p>	06/25/2013			

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	<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 2 of 3 basement smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Maintenance on 06/11/13 at 12:45 p.m., the basement fire wall between the resident storage area and the east basement had an unsealed one half inch penetration around a conduit line. This wall was confirmed to be a fire wall and the measurement was provided by the Director of Maintenance.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 20 of 20 resident rooms in the 300 and 400 halls. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice affects any of the 22 residents in the 300 and 400 halls.</p>			

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	<p>Findings include:</p> <p>Based on record review of the "Battery-Operated Smoke Detector Maintenance Log" with the Director of Maintenance on 06/11/13 at 11:18 a.m., the batteries in the smoke detectors on the 300 and 400 hall have not been replaced since March of 2012. This was acknowledged by the Director of Maintenance at the time of record review.</p> <p>3.1-19(b)</p>			
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K010143 SS=B	<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 provided posted signs indicating transferring is occurring in 1 of 1 oxygen transferring locations. This deficient practice could affect 1 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 06/11/13 at 2:37 p.m., the oxygen transferring room lacked the required sign stating transferring is occurring. At the time of observation, the Director of Maintenance confirmed the oxygen room was used for oxygen transferring and the door lacked the proper signage.</p>	K010143	Signs have been provided and the policy for oxygen transfer revised to require the posting of the appropriate sign during the transfer. See Exhibits # 6 & #7: the policy for "Filling Portable Oxygen Units" and the sign to be posted during oxygen transfers.	06/28/2013			

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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 1 of 1 sprinklered elevator equipment rooms was provided with an automatic means for disconnecting the main line power supply. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main line 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 any residents in the elevator near the main nurses' station going to the basement resident storage area.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 06/11/13 at 1:00 p.m., the basement elevator equipment room was provided with sprinkler coverage.</p>	K010160	Shunt trips for the Elevator Equipment Rooms in Health Care and in Crestwood have been ordered. See Exhibit # 8, Accepted quote for shunt trips.	08/01/2013			

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	<p>Based on an interview with the Director of Maintenance at 11:30 a.m., he was aware a shunt trip was needed for the elevator equipment but at this time the equipment lacked a shunt trip to automatically disconnect the main line power supply while sprinklers were activated.</p> <p>3.1-19(b)</p>			

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K020000	<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: 06/11/13</p> <p>Facility Number: 000448 Provider Number: 155740 AIM Number: 100275140</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist and Robert Sutton, Life Safety Code Specialist Trainee</p> <p>At this Life Safety Code survey, Timbercrest Church of Brethren Home 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) and 410 IAC 16.2. The new section of the building consisting of the kitchen, main dining room and the Crestwood wing was surveyed with Chapter 18, New Health Care Occupancies</p> <p>This one story facility with a basement was determined to be of Type V (111)</p>	K020000					

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	<p>construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, in areas open to the corridor and in the resident rooms in Crestwood. The facility has a capacity of 65 and had a census of 62 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached maintenance garage.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K020018 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Crestwood clean linen storage area corridor doors closed and latched into the door frame. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 06/11/13 at 1:46 p.m., the clean linen storage area on the Crestwood hall was designed with double corridor doors. One door was equipped with a manual latching device that would latch into the door frame and the remaining door was designed to latch into the stationary door. Each door could not latch automatically, and independent of the other door, into the door frame. This was acknowledged by the Director of Maintenance at the time of observations.</p> <p>3.1-19(b)</p>	K020018	The closets in question will be modified with spring closing hinges to keep doors closed when not in use. The inactive door will have an automatic latching bolt to latch the door when the door is closed. The active door would operate as it does latching into the inactive door. Door coordinators will assure that doors close in the proper sequence to assure latching. See attached Exhibit #1 Accepted quote for revision to closet doors.	08/01/2013			

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K020020 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and sprinklered buildings up to three stories in height.) 18.3.1.1.</p> <p>An atrium may be used in accordance with 8.2.2.3.5.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 stairway doors in Crestwood had a one hour rating, closed and latched into the door frame. LSC 18.3.1.1 requires any vertical opening to be enclosed or protected in accordance with LSC 8.2.5. LSC 8.2.5.2 states the vertical opening shall be enclosed as appropriate for the fire resistance rating of the barrier. LSC 8.2.3.3.1 requires a one hour rated door in a one hour vertical opening. NFPA 80, the Standard for Fire Doors and Fire Windows at 2-1.2 requires fire door assemblies to include latches. NFPA 80, 2-1.4 requires fire doors to be closed and latched at the time of fire. This deficient practice could affect any of the 16 residents on Crestwood hall.</p> <p>Findings include:</p> <p>Based on an observation with the Director</p>	K020020	An order has been placed to have the door in question equipped with a door closer, a set of flush bolts to latch when the active door closes and a coordinator to close the inactive door before the active door. See Exhibit # 1.	08/01/2013			

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	<p>of Maintenance on 06/11/13 at 1:45 p.m., Crestwood hall stairway near the nurses' station was designed with a double corridor door. One door was equipped with a manual latching device that would latch into the door frame and the remaining door was designed to latch into the stationary door. Each door could not latch automatically, and independent of the other door, into the door frame. This was acknowledged by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p>			

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K020029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure 3 of 3 serving windows and 2 of 2 doors entering the kitchen, a hazardous area, were smoke resistant and latched into the door frame. This deficient practice could affect any residents in the main dining room with a seating capacity of more than 20 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 06/11/13 at 2:16 p.m., the kitchen was located next to the main dining room. The two doors entering the kitchen were manually operated sliding pocket doors and the three serving window had decorative bifold wooden glass windows that were manually closed after each meal. This was acknowledged by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p>	K020029	The two pocket doors between the Health Care Kitchen and the Health Care Dining Room will be replaced with swinging doors equipped with automatic closures and self-latching hardware. They will be held open with magnetic devices wired to the fire alarm system to close automatically in the event of an alarm. Two of the serving windows will be sealed with trim pieces providing for the smoke stop barrier and rendering the windows inoperable. This work will be completed by August 1, 2013. See Exhibit #9. The third serving window will be provided with a Cookson Coiling Fire/Smoke Door equipped with a smoke alarm connection. The lead time for this item is 60 to 90 days so project completion will be October, 1, 2013. See Exhibit #10	09/01/2013			

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K020038 SS=B	<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. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 exit doors 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 SECONDS". This deficient practice could affect any of the 16 residents on the Crestwood hall.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 06/11/13 at 2:00 p.m., the north stairwell exit door on the Crestwood hall was equipped with electromagnetic locks that released after pushing the door for 15 seconds, but a sign about the 15 second delay was not posted. At the time of observation, the Director of Maintenance acknowledged the north stairwell exit door lacked a sign with the required verbiage.</p>	K020038	Signs have been posted on the subject doors to meet the requirement.	07/02/2013			

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K020046 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1</p> <p>Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency light fixtures of at least 1½ hour duration was tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. In addition, NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 06/10/13 at 3:15 p.m., a battery operated emergency light was observed at the emergency generator. Based on record review at 11:55 a.m., the last annual ninety minute test on the</p>	K020046	Annual 90 minute test of the emergency light was successfully conducted on June 28, 2013. A recurring work order has been entered into the Maintenance Work Order system to produce an order for the annual test each June. See Exhibits # 2 & #3: Work Order for 90 minute test and Test Log showing test completed on June 28, 2013.	06/28/2013			

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	<p>battery operated light was March of 2012. Based on an interview with the Director of Maintenance at the time of record review, the light had not received an annual test since March of 2012.</p> <p>3.1-19(b)</p>			

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K020061 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 water inlet Outside Screw and Yoke (OS&amp;Y) valves for the sprinkler system were electronically supervised. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 06/11/13 at 12:40 p.m., the water inlet OS&amp;Y valves at the basement sprinkler riser were secured in the open position with a chain and a padlock, however, there was no electronic supervision of the valves. Based on an interview with the Director of Maintenance at the time of observation, the valves have always been chained in the open position.</p> <p>3.1-19(b)</p>	K020061	The required electronic tamper alarms have been ordered to be installed on the OS & Y valves in question.	09/01/2013			

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K020064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Beauty Shop portable fire extinguishers was mounted so the top of the extinguisher was no more than five feet (60 inches) above the floor. NFPA 10, Section 1-6.10 requires fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so the top of the fire extinguisher is not more than 5 feet (60 inches) above the floor. This deficient practice could affect 1 or possibly 2 residents in the Beauty Shop.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 06/11/13 at 1:35 p.m., the fire extinguisher mounted on the wall in the Beauty Shop measured five foot five inches from the floor to the top of the fire extinguisher. The measurement was provided by the Director of Maintenance.</p> <p>3.1-19(b)</p>	K020064	The portable fire extinguisher in the Beauty Shop has been lowered. The top of the extinguisher is now at approximately 40" above the finished floor.	06/21/2013			

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K020161 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD All elevators, escalators, and conveyors comply with ASME/ANSI A17.1, Safety Code for Elevators and Escalators. 9.4, 18.5.3 Based on observation and interview, the facility failed to ensure 1 of 1 sprinklered elevator equipment rooms was provided with an automatic means for disconnecting the main line power supply. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main line 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 was not in a resident care area but could affect any number of facility staff using the elevator near the Crestwood nurses' station.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 06/11/13 at 2:05 p.m., the Crestwood hall basement elevator equipment room was provided with sprinkler coverage. Based on an interview with the Director of Maintenance at 11:30 a.m., he was aware</p>	K020161	K 161 _ Shunt trips for the Elevator Equipment Rooms in Health Care and in Crestwood have been ordered. See Exhibit # 8, Accepted quote for shunt trips.	08/01/2013			

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	<p>a shunt trip was needed for the elevator equipment but at this time the equipment lacked a shunt trip to automatically disconnect the main line power supply while sprinklers were activated.</p> <p>3.1-19(b)</p>			