

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155022	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/22/2015
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NAME OF PROVIDER OR SUPPLIER  HERITAGE HOUSE OF SHELBYVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2309 S MILLER ST SHELBYVILLE, IN 46176
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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: 01/22/15</p> <p>Facility Number: 000009 Provider Number: 155022 AIM Number: 100274760</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Heritage House of Shelbyville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and fully sprinkled except sixteen resident room ceiling light locations. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke</p>	K010000	<p>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 forth in the statement of deficiencies.</p> <p>The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K010025 SS=F	<p>detectors in all resident sleeping rooms. The facility has a capacity of 141 and had a census of 75 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled except sixteen resident room ceiling light locations and all areas providing facility services were sprinkled.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 01/28/15.</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 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observations and interview, the facility failed to ensure the smoke barriers in 1 of 1 ceiling and 3 of 6 attic</p>	K010025	<b>K 025 NFPA 101 Life Safety Code Standard</b>	02/21/2015

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	<p>smoke barriers were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on observations with the assistant maintenance supervisor during a tour of the facility on 01/22/15 from 9:45 a.m. to 3:50 p.m., the following locations had ceiling and attic smoke barrier penetrations not firestopped or missing drywall;</p> <ol style="list-style-type: none"> <li>1. The Station 3 South Hall attic smoke barrier wall had four, two inch to eight inch circular areas of drywall missing.</li> <li>2. The Station 3 North Hall attic smoke barrier wall had seven, two inch to six inch gaps around electrical conduit and water pipe penetrations not fire stopped.</li> <li>3. The Station 2 Hall attic smoke barrier wall had four open electrical conduit pipes not fire stopped and three foot by fifty foot section of drywall missing</li> </ol>		<p>It is the practice of the facility to maintain smoke barriers that are constructed to provide at least one half hour of fire resistance rating in accordance with 8.3.</p> <p>There were no specific residents identified in this finding. The corrective action will address those residents with the potential to be affected by this finding.</p> <p>All areas were corrected by one of the following procedures: 1) fire caulking, drywall, or thermafiber (Fire Blanket insulation (SAFB)).</p>	

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K010027 SS=E	<p>along the entire bottom length of the smoke barrier wall on both sides of the smoke barrier.</p> <p>4. The maintenance office ceiling had three, one half inch gaps around computer cable penetrations not fire stopped.</p> <p>5. The Station 4 Hall fire alarm main panel room ceiling had a one half inch gap around a computer cable penetration not fire stopped.</p> <p>6. The State 2 Hall electrical room ceiling had one inch gap around a computer cable bundle penetration and four, one inch gaps around electrical conduit penetrations not fire stopped. The Station 2 Hall, Station 3 Hall and Station 4 Hall attic smoke barrier penetrations not fire stopped and missing drywall, and the maintenance office ceiling, Station 4 Hall fire alarm main panel room ceiling, and Station 2 Hall electrical room ceiling not fire stopped was verified by the assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 01/22/15 at 3:55 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are</p>		Maintenance will do a walk through of the facility with administrator 2 times week for 4 weeks, the 1 time week for 4 weeks, then monthly for 10 months and findings will be taken to QA times 12 months.		

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	<p>at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 3 of 14 sets of smoke barrier doors and 1 of 6 attic smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 21 residents who reside on the Station 2 Hall and 33 residents who reside on the Station 3 Hall.</p> <p>Findings include:</p> <p>Based on observation on 01/22/15 from 9:45 a.m. to 3:50 p.m. with the assistant maintenance supervisor, the Station 3 Hall set of smoke barrier doors by the oxygen storage room, the set of smoke barrier doors down the kitchen corridor, and the Station 3 Hall set of smoke</p>	K010027	<p><b>F 027 NFPA Life Safety Code Standard</b></p> <p>It is the practice of the facility to ensure that door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4 –inch thick solid bonded wood core.</p> <p>There were no specific residents identified in this finding. The corrective action will address those residents with the potential to be affected by this finding.</p>	02/21/2015			

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K010029 SS=E	<p>barrier doors by the business office had between a one inch gap and a two inch gap along the center where the doors came together in the closed position. Furthermore, the attic smoke barrier door at the Station 3 Hall north was propped open four inches by electrical wire. This was verified by the assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 01/22/15 at 3:50 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied</p>		<p>All smoke barrier doors, and the attic smoke barrier door have been repaired.</p> <p>Smoke barrier doors will be checked by maintenance and administrator 2 times weekly for 4 weeks, then one time weekly for 4 weeks, then monthly for 10 months. Results will be taken to QA times 12 months.</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 observations and interview, the facility failed to ensure 2 of 24 hazardous areas such as a combustibile storage rooms over 50 square feet and trash collection room, were provided with self closing devices which would cause the doors to automatically close and latch into the door frame or latching hardware. This deficient practice could affect 33 residents who reside on the Station 3 Hall.</p> <p>Findings include:</p> <p>Based on observations on 01/22/15 during a tour of the facility with the assistant maintenance supervisor from 9:45 a.m. to 3:50 p.m., the Station 3 Hall clean linen room, which measured one hundred twenty square feet and stored twelve shelves of combustibile clean linen, had a two inch gap when the door was allowed to self close and failed to latch into the door frame.</p> <p>Furthermore, the trash collection room, located in the kitchen corridor, was not provided with a strike plate and failed to latch. This was verified by the assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on</p>	K010029	<p><b>K 029 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of the facility to maintain self-closing doors on hazardous areas.</p> <p>There were no specific residents identified in this finding. The corrective action will address those residents with the potential to be affected by this finding.</p> <p>Strike plate was replaced on the trash collection door and clean linen room door self closing device was adjusted. All doors in the facility that are self</p>	02/21/2015

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K010050 SS=F	<p>01/22/15 at 3:55 p.m.</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 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 Based on record review and interview, the facility failed to conduct quarterly fire drills on all shifts for 2 of 4 quarters over</p>	K010050	<p>closing were checked to ensure they were working properly.</p> <p>Maintenance will check all self closing doors for proper closing 2 times weekly for 4 weeks, then 1 times weekly for 4 weeks then monthly for 10 months. Results will be taken to QA times 12 months.</p> <p><b>K 050 NFPA Life Safety Code Standard</b></p>	02/21/2015

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	<p>the past year. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports with the assistant maintenance supervisor on 01/22/15 at 9:00 a.m., there was no fire drill documenting for the third shift, first quarter of the year 2014 and second shift second quarter for the year 2014. Additionally, based on interview with the assistant maintenance supervisor during the review of the Fire Drill Report, there was no other documentation available for review to verify these drills were conducted. This was verified by the assistant maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 01/22/15 at 3:55 p.m.</p> <p>3.1-19(b)</p>		<p>It is the practice of the facility to conduct fire drills monthly, with one being on each shift quarterly. Fire drills are unexpected times with varying conditions.</p> <p>There were no specific residents identified in this finding. The corrective action will address those residents with the potential to be affected by this finding.</p> <p>A calendar has been set for the next 12 months. Fire drills to be done by maintenance department. Will be audited monthly by administrator and results taken to QA for 12 months.</p>		

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K010056 SS=E	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></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 16 of 68 resident room recessed ceiling light locations were sprinkled. This deficient practice affects 32 residents in the facility.</p> <p>Findings include:</p> <p>Based on observations on 01/22/15 during a tour of the facility from 9:45 a.m. to 3:50 p.m. with the assistant maintenance supervisor, resident rooms 1, 8, 9, 10, 11, 12, 13, 14, 15, 16,17,18, 19, 20, 21, and 22 each had an enclosed bulkhead in a recessed wall location with a light fixture located in the enclosed bulkhead. Furthermore, the enclosed bulkhead inside dimension measured three foot by three foot and each resident</p>	K010056	<p><b>K 056 NFPA 101 Life Safety Code Standard</b></p> <p>The facility is equipped with an automatic sprinkler system; it is installed in accordance with NFPA 13. Sprinkler system does provide complete coverage for all portions of the building.</p>	03/21/2015
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K010062 SS=E	room bulkhead was not provided with sprinkler coverage. This was verified by the assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 01/22/15 at 3:55 p.m.  3.1-19(b)  NFPA 101 LIFE SAFETY CODE STANDARD		There were no specific residents identified in this finding. The corrective action will address those residents with the potential to be affected by this finding.  The areas in question, the lights were removed and opening enclosed with drywall; then a enclosed light fixture was placed. These areas can be reached by sprinklers already in rooms.  An extension of completion date is requested for this citing; work will be completed by March 21, 2015.		

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	<p>Required automatic sprinkler systems are 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>1. Based on observation and interview, the facility failed to replace 14 of over 300 sprinklers in the facility which were painted, corroded or loaded. LSC 9.7.5 requires all automatic sprinkler systems shall 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, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 62 residents who use the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observations on 01/22/15 during a tour of the facility from 9:45 a.m. to 3:50 p.m. with the assistant maintenance supervisor, the kitchen had thirteen sprinklers throughout the kitchen covered in black grease and the administrator office bathroom had one sprinkler covered in white paint. This was verified by the assistant maintenance supervisor at the time of observations and</p>	K010062	<p><b>K 062 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to ensure that required sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.</p> <p>There were no specific residents identified in this finding. The corrective action will address those residents with the potential to be affected by this finding.</p> <p>The sprinkler heads in</p>	02/21/2015

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K010066 SS=E	<p>acknowledged by the administrator at the exit conference on 01/22/15 at 3:55 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 5 of over 300 sprinkler heads in the facility were maintained. This deficient practice could affect 33 residents who reside on the Station 3 Hall.</p> <p>Findings include:</p> <p>Based on observations on 01/22/15 during a tour of the facility from 9:45 a.m. to 3:50 p.m. with the assistant maintenance supervisor, the kitchen storage room sprinkler, the two sprinklers in the employee break room, the Station 3 Hall corridor sprinkler by the smoke barrier set of doors, and the trash room sprinkler were missing the escutcheon. This was verified by the assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 01/22/15 at 3:55 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		<p>question were either cleaned or replaced, and those that had missing or loose escutcheons were either repaired or replaced.</p> <p>Maintenance department will check sprinkler heads 2 times weekly for 4 weeks, then 1 time weekly for 4 weeks, then monthly x 8. Results will be taken to QA x 12 months.</p>		

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	<p>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</p> <p>Based on observation, record review, and interview, the facility failed to ensure 1 of 4 area where smoking was permitted used the metal self closing containers for discarded smoking material. This deficient practice could affect 21 residents who reside on the Station 4 Hall near the visitors entrance.</p> <p>Findings include:</p> <p>Based on observation on 01/22/15 at 8:50 a.m. with the assistant maintenance supervisor, the outside visitor entrance smoking location had fifty discarded</p>	K010066	<p><b>K 066 NFPA 101 Life Safety Code Standard</b> It is the practice of the facility to follow smoking regulations. There were no specific residents identified in this finding. The corrective action will address those residents with the potential to be affected by this finding. Area that had cigarette butts were cleaned up and plastic plant container was removed and all other areas checks. Non combustible ashtrays and a metal container with self closing lid have been provided for smoking areas and at each entrance. Areas will be checked by housekeeping 3 times a week for</p>	02/21/2015

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K010067 SS=F	<p>cigarette butts on the ground surface mixed with wood mulch and on the concrete sidewalk. Furthermore, the smoking location was used a plastic plant container for an ashtray and was not provided with a non combustible ashtray and metal containers with self closing lid for discarded smoking material. This was verified by the assistant maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 01/22/15 at 3:55 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>1. Based on observation and interview, the facility failed to ensure 9 of 9 egress corridors were not being used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply return or exhaust air system serving adjoining areas. This</p>	K010067	<p>4 weeks, then 2 times a week for 4 weeks, then 1 time a week for 4 weeks, then monthly x 9 months. Results will be brought to QA.</p> <p><b>K 067 NFPA 101 Life Safety Code Standard</b> The Heritage House of Shelbyville respectfully requests a waiver for this finding. Smoke detectors are located in the areas identified in this finding. Activation of the fire alarm system will trigger relays that shut down the air handlers in these portions of the building. Once the air handler is closed, smoke will be prevented from transferring from one smoke zone to another. Modification to the existing air handling system will</p>	02/21/2015

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	<p>deficient practice affects all resident in the facility.</p> <p>Findings include:</p> <p>Based on observations on 01/22/15 during a tour of the facility from 9:45 a.m. to 3:50 p.m. with the assistant maintenance supervisor, all resident rooms in the facility used the egress corridors as a return air system for the air conditioning system in the facility. This was verified by the assistant maintenance supervisor at the time of observations acknowledged by the administrator at the exit conference on 01/22/15 at 3:55 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 2 of 2 fire dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully</p>		<p>pose a hardship for residents displaced during the installation process. The facility would also incur financial hardship for an estimated cost of \$59,000 conservatively to upgrade the air handling system to meet this requirement. The history of the facility, reflects no incidents resulting from this finding. Attachment A – Plan of Correction Attachment B – HVAC quote Attachment C – SF 54147 LSC Waiver Attachment D – Facility Floor Plan Attachment E – Income Statement</p>	

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K010069 SS=F	<p>close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects 21 residents who reside on the Station 2 Hall.</p> <p>Findings include:</p> <p>Based on record review on 01/22/15 at 9:30 a.m. with the assistant maintenance supervisor, the assistant maintenance supervisor indicated the Station 2 Hall had two fire dampers in the supply air ducts in the corridor. Based on a records search on 01/22/15 at 9:40 a.m., the assistant maintenance supervisor indicated there were no inspection records available for review for the two Station 2 Hall fire dampers. This was verified by the assistant maintenance supervisor during the record review and acknowledged by the administrator at the exit conference on 01/22/15 at 3:55 p.m.</p> <p>3.1-19(b)</p> <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 record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected at least semiannually. NFPA 96, 1998 Edition,</p>	K010069	<b>K 069 NFPA 101 Life Safety Code Standard</b>	02/21/2015

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	<p>Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1 requires systems serving moderate volume cooking operations shall be inspected semiannually. This deficient practice could affect all resident in the facility.</p> <p>Findings include:</p> <p>Based on record review on 01/22/15 at 9:15 a.m. with the assistant maintenance supervisor, there were no kitchen exhaust inspection records available for review. Based on an interview with the assistant maintenance supervisor on 01/22/15 at 9:20 a.m., it was indicated the maintenance staff cleans the hood system when it is needed and there are no records of inspections by a properly trained, qualified, and certified company or person. The lack of semi-annual</p>		<p>It is the practice of the facility to ensure that cooking facilities are protected in accordance with 9.2.3 19.3.26, NFPA 96</p> <p>There were no specific residents identified in this finding. The corrective action will address those residents with the potential to be affected by this finding.</p> <p>The kitchen hood is scheduled to be cleaned and inspected on February 12, 2015. Cleaning and inspection will be done bi-annually on going.</p> <p>Dietary Manager will</p>	

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K010143 SS=E	<p>kitchen exhaust inspections for the past year was verified by the assistant maintenance supervisor at the time of record review and interview and acknowledged by the administrator at the exit conference on 01/22/15 at 3:55 p.m.</p> <p>3.1-19(b)</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b> 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 2 of 2 oxygen storage/transfer locations were provided with a separation of 1 hour fire resistive construction from resident occupied areas. This deficient practice could affect 33 residents who reside on the Station 3 Hall which is near the liquid oxygen</p>	K010143	<p>ensure that hood is cleaned and inspected bi-annually and report to QA.</p> <p><b>K 143 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of the facility to ensure that the</p>	02/21/2015

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K010147 SS=E	<p>storage room and 21 residents who reside on the Station 4 Hall near the liquid oxygen storage room.</p> <p>Findings include:</p> <p>Based on observations with the assistant maintenance supervisor on 01/22/15 from 3:10 p.m. to 3:20 p.m., the Station 3 Hall and Station 4 Hall liquid oxygen storage rooms, where three full liquid oxygen containers were stored in each room, each room door were provided with a door label indicating the doors were a thirty minute fire rated door. The lack of doors with at least a forty five minute fire rating for the Station 3 and Station 4 liquid oxygen storage rooms was acknowledged by the administrator at the exit conference on 01/22/15 at 3:55 p.m.</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 Based on observation and interview, the facility failed to ensure 5 of 125 wet location resident care areas were</p>	K010147	<p>transfer of Oxygen takes place in a area that is in accordance with NFPA 99.</p> <p>There were no specific residents identified in this finding. The corrective action will address those residents with the potential to be affected by this finding.</p> <p>Doors to both oxygen transfer rooms were replaced with 1 ½ hour doors.</p> <p><b>K 147 NFPA 101 Life Safety Code Standard</b></p>	02/21/2015			

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	<p>provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas that are subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affects 12 residents who use the therapy room and staff.</p> <p>Findings include:</p> <p>Based on observations with the assistant maintenance supervisor on 01/22/15 during a tour of the facility from 9:45 a.m. to 3:50 p.m., the code cart room two electric outlets, the employee breakroom two electric outlets, and the therapy room electric outlet were located within two feet of handwash basins with no ground fault circuit interrupters on the electric outlets. Based on observation of the main electrical breaker panels with the</p>		<p>It is the practice of this facility to ensure that all electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2.</p> <p>There were no specific residents identified in this finding. The corrective action will address those residents with the potential to be affected by this finding.</p> <p>Ground fault circuit interrupters (GFCI) were installed in all areas listed.</p> <p>Maintenance will continue to ensure that</p>	

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	assistant maintenance supervisor at the time of observations, the circuit breakers for the electric outlets were not provided with GFCI protection. This was verified by the assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 01/22/15 at 3:50 p.m.  3.1-19(b)		these are installed in locations that are subject to wet conditions while residents present.		