

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/22/2014
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NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/22/14</p> <p>Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Carmel Health and Living Community 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 a partial walkout lower level was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has smoke</p>	K010000	<p>Submission of this plan of correction does not constitute an admission by Carmel Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. This provider respectfully requests that the 2567 plan of correction be considered as the letter of credible allegation and respectfully request a desk review on or after October 22, 2014.</p>	
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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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K010038 SS=E	<p>detectors hard wired to the fire alarm system in resident sleeping rooms in the 700 and 800 halls. The facility has battery operated smoke detectors in resident sleeping rooms in the 200, 300, 400 and 500 halls. The facility has a capacity of 188 and had a census of 146 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the camera closet inside the Front stairwell.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/25/14.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure exit access was arranged so 1 of 4 exits leading out of Station 2 were readily accessible at all times. LSC Section 7.1.6.2 states abrupt changes in elevation of walking surfaces</p>	K010038	K 038 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. What corrective action(s) will be accomplished	10/22/2014
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	<p>shall not exceed one quarter inch. This deficient practice could affect 28 residents using the direct exit to evacuate out of Station 2 as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 09/22/14 at 1:45 p.m. with the Maintenance Supervisor, the direct exit leading out of Station 2 southeast had a drain pipe opening two feet in front of the exit door and was not provided with a drain cover thereby exposing a six inch diameter by three inch deep opening which could easily cause a tripping hazard for residents. Based on interview on 09/22/14 at 1:48 p.m. with the Maintenance Supervisor it was acknowledged the six inch diameter drain opening in the concrete outside the Station 2 southeast exit was in need of a drain cover.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure exit access was arranged so 2 of 10 exits were readily accessible at all times. LSC Section 7.2.5.4 requires handrails complying with 7.2.2.4 shall be provided along both sides of a ramp run with a rise greater than six inches. LSC Section</p>		<p>for those residents found to have been affected by the deficient practice? Residents residing on units 200 and 700 have the potential to be affected by the alleged deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>1. The drain cover was replaced on the day of the survey. 2 A quote has been accepted by the provider and the handrails are being manufactured for install within 45 days after 10/15/14</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? _ 1. The maintenance director will make external facility rounds weekly x four weeks and monthly thereafter to ensure the drain cap is in place. The monthly rounds will be added to the facility Preventative Maintenance TEL's system. 2. The handrails will be installed to both ascending ramps by 12/1/14. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The maintenance director will make external facility rounds weekly x four weeks and monthly</p>				

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K010046 SS=E	<p>7.2.2.4.2 Exception #3 requires that an existing ramp shall have a handrail on at least one side. This deficient practice could affect 28 residents on Station 2 southeast and 12 residents on Station 7 northwest as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 09/22/14 during the tour between 1:45 p.m. to 2:15 p.m. with the Maintenance Supervisor, the Station 2 southeast exit led to an ascending exit discharge ramp which lacked handrails. The cement ramp was ten feet long and was measured with the Maintenance Supervisor to have a slope of seven inches in two feet of walkway and was not provided with a handrail. Furthermore, Station 7 northwest had an ascending ramp which measured two inch rise in two feet of walkway and was not provided with a handrail. Both exits were located on Long Term Side. Based on interview on 09/22/14 during the measurement at 1:50 p.m. with the Maintenance Supervisor it was confirmed the slope measurement was accurate and no handrails were provided.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour</p>		<p>thereafter and document findings and turn into the administrator. The monthly rounds will be added to the facility Preventative Maintenance TEL's system. Any identified concerns from rounds will be addressed immediately. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Compliance Date: 10/22/14</p>				

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	<p>duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on interview and observation, the facility failed to provide exterior emergency lighting for 4 of 4 exits on Station 2 east. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect 28 residents as well as staff and visitors if the occupants in the facility were required to evacuate in an emergency.</p> <p>Findings include:</p> <p>Based on observation on 9/22/14 at 1:59 p.m. with the Maintenance Supervisor there was no lighting, emergency or otherwise for four exits which discharge onto Station 2 east walkway. Based on interview on 9/22/14 at 2:00 p.m. with the Maintenance Supervisor it was acknowledged the Station 2 southeast exit discharge lacked exterior emergency lights to illuminate walkway during a power outage.</p> <p>3.1-19(b)</p>	K010046	<p>K 046 NFPA 101 Life Safety Code Standard</p> <p>Emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9 19.2.9.1.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents residing on unit 200 have the potential to be affected by the alleged deficient practice.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Lighting was installed by the maintenance staff on 9-26-14.</p>	10/10/2014	

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			<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>-</p> <p>The maintenance director will make external facility rounds weekly x four weeks and monthly thereafter to ensure the external emergency lighting is illuminating the exit access and exit egress. The monthly rounds will be added to the facility Preventative Maintenance TEL's system.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The maintenance director will make external facility rounds weekly x four weeks and monthly thereafter and document findings and turn into the administrator. The monthly rounds will be added to the facility Preventative Maintenance TEL's system.</p>		

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K010056 SS=E	<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 rooms inside the Front stairwell in Manor House was provided with an automatic sprinkler head to ensure sprinkler coverage in all portions of the building. This deficient</p>	K010056	<p>Any identified concerns from audits will be addressed immediately.</p> <p>The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Compliance Date: 10/10/14</p> <p>K 056 NFPA 101 Life Safety Code Standard</p> <p>If there is an automatic</p>	10/10/2014			

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	<p>practice could affect 24 residents on Station 8 as well as visitors or staff.</p> <p>Findings include:</p> <p>Based on observation on 09/22/14 at 12:10 p.m. with the Maintenance Supervisor, the camera closet just inside and to the left of Front stairwell in Manor House was not provided with sprinkler head protection. Based on interview on 09/22/14 concurrent with the observation it was acknowledge by the Maintenance Supervisor, the aforementioned room was not equipped with sprinkler head protection in order to provide complete sprinkler coverage to all areas of the facility.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>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.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents residing on unit 800, as well as visitors and staff, have the potential to be affected by the alleged deficient practice.</p> <p>How will you identify other residents having the potential to be affected by the same</p>		

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			<p>deficient practice and what corrective action will be taken?</p> <p>A sprinkler head was installed on 10-3-14.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>-</p> <p>The facility contracts with PIPE who makes quarterly inspections of facility property to ensure the building is within NFPA 13 and NFPA 25 requirements...</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The facility will respond to any findings from quarterly visits from the sprinkler vendor and ensure the building is within code.</p>		

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K010062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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>Based on observation, record review and interview; the facility failed to ensure 2 of 2 pressure gauges for the sprinkler system in the Riser room were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent</p>	K010062	<p>Any identified concerns from audits will be addressed immediately.</p> <p>The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Compliance Date: 10/10/14</p> <p>K 062 NFPA 101 Life Safety Code Standard</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.</p>	10/10/2014

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	<p>of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation on 09/22/14 at 2:38 p.m. with the Maintenance Supervisor, two sprinkler pressure gauges in the sprinkler riser room in the basement west wall had manufacturer's dates of 2007. Based on Sprinkler Inspection Records review on 09/22/14 at 4:15 p.m. with the Maintenance Supervisor, documentation did not reveal the sprinkler system gauges had been calibrated since the last date. Based on interview on 09/22/14 concurrent with the observation it was acknowledged by the Maintenance Supervisor the pressure gauges had exceeded the five year requirement for recalibration or replacement.</p> <p>3.1-19(b)</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>All residents, staff and visitors could be potentially affected by the alleged deficient practice.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>The pressure gauges were changed out on 10-1-14.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>-</p> <p>The facility changed sprinkler/fire protection providers in September, 2014.</p>		

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			<p>PIPE will make quarterly inspections of the facility sprinkler system to ensure it is compliant of NFPA 13 and NFPA 25.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The facility will respond to any findings from quarterly visits from the sprinkler vendor and ensure the building is within code.</p> <p>Any identified concerns from audits will be addressed immediately.</p> <p>The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p>		

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K010064 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 5 of 44 portable fire extinguishers were installed correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect 8 residents observed near Woodland Satellite kitchen and 44 residents on Station 7 and 8 in Manor House as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 09/22/14 during the tour between 12:05 p.m. to 2:33 p.m. with the Maintenance Supervisor, the following fire extinguishers were measured to be installed with the top of the fire extinguishers at sixty nine inches from the floor:</p>	K010064	<p>Compliance Date: 10/10/14</p> <p>K 064 NFPA 101 Life Safety Code Standard</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1 19.3.5.6, NFPA 10.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents residing near Woodland Dining area, unit 700 and 800, staff and visitors, could potentially be affected by the alleged deficient practice.</p> <p>How will you identify other residents having the potential to be affected by the same</p>	10/10/2014	

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	<p>a. Portable extinguisher located next to room 813 Station 8</p> <p>b. Portable extinguisher located in Therapy room on Station 7</p> <p>c. Portable extinguisher located in Therapy hall, Station 7</p> <p>d. Portable extinguisher located next to room 703 on Station 7</p> <p>e. Portable extinguisher located in Woodland Satellite kitchen north wall on Long Term</p> <p>Based on interview on 09/22/14 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned portable fire extinguishers were over sixty inches from the floor.</p> <p>3.1-19(b)</p>		<p>deficient practice and what corrective action will be taken?</p> <p>The portable fire extinguishers were changed out with shorter fire extinguishers that meet the height requirement of not more than 42 inches above the floor on 9-29-14.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>-</p> <p>The facility contracts with PIPE who makes quarterly inspections of facility property to ensure the building is within NFPA10 requirements.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p>		

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K010143 SS=E	<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>The facility will respond to any findings from quarterly visits from the sprinkler vendor and ensure the building is within code.</p> <p>Any identified concerns from audits will be addressed immediately.</p> <p>The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Compliance Date: 10/10/14</p>		

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	<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 1 oxygen storage rooms where oxygen transfer occurs had continuously working, electrically powered mechanical ventilation. This deficient practice could affect 18 residents on Station 3 as well as visitors and staff in the area.</p> <p>Findings include:</p> <p>Based on observation on 09/22/14 at 12:46 p.m. with the Maintenance Supervisor, the oxygen storage room Station 3, Long Term side used to store and transfer oxygen was provided with an open air chute to the outside, but did not have electrically powered mechanical ventilation. Based on interview on 09/22/14 at 12:50 p.m. it was acknowledged by the the Maintenance Supervisor this room was used to transfer oxygen and was unaware it was required to have electrically powered mechanical ventilation.</p> <p>3.1-19(b)</p>	K010143	<p>K 143 NFPA 101 Life Safety Code Standard</p> <p>Transferring of oxygen is:</p> <p>In an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring. NFPA 99 8.6.2.5.2</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents residing on unit 300, staff and visitors, have the potential to be affected by the alleged deficient practice.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what</p>	10/10/2014	

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			<p>corrective action will be taken?</p> <p>A mechanical ventilation system was installed by the maintenance staff on 10-7-14.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>-</p> <p>The maintenance director will make facility rounds to ensure the ventilation is working appropriately daily.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The maintenance director will make facility rounds to ensure the ventilation is working appropriately daily. The rounds will be added to the facility</p>		

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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of</p>	K010144	<p>Preventative Maintenance TEL's system.</p> <p>Any identified concerns will be addressed immediately.</p> <p>Any concerns discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Compliance Date: 10/10/14</p> <p>K 144 NFPA 101 Life Safety Code Standard</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1</p> <p>What corrective action(s) will</p>	10/10/2014

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	<p>generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Generator System Testing records and Maintenance logs on 09/22/14 at 3:38 p.m. with the Maintenance Supervisor, the amperage during load could not be verified to be at thirty percent of the EPS nameplate rating and no other method was used to document monthly load for the past twelve months. Based on interview on 09/22/14 concurrent with record review with the Maintenance Supervisor, it was acknowledged the facility had been</p>		<p>be accomplished for those residents found to have been affected by the deficient practice?</p> <p>All residents residing in the facility, staff and visitors have the potential to be affected by the alleged deficient practice.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>The corporate maintenance director inserviced facility maintenance staff on correctly documenting the formula for running the generator under a 30% load on 9-24-14.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>-</p> <p>The maintenance director has documented the correct</p>				

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	<p>running the generator monthly, but was unaware it had to be documented at 30 percent and no other equivalent method was used to comply with percentage of load capacity for the past twelve months.</p> <p>3.1-19(b)</p>		<p>information for the last 2 weeks and will continue weekly...</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The maintenance director has documented the correct information for the last 2 weeks and will continue weekly. The documentation will be added to the facility Preventative Maintenance TEL's system.</p> <p>Any identified concerns from audits will be addressed immediately by corporate maintenance staff on monthly visits.</p> <p>The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Compliance Date: 10/10/14</p>		

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K010160 SS=F	<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, interview and record review; the facility failed to ensure the elevator equipment in 2 of 2 elevator equipment rooms was provided with a shunt trip. 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 power supply to the affected elevator automatically upon, or prior to, the application of water from the sprinkler located in the elevator machine room. The elevator equipment rooms were located in the basement of Manor House and could affect any resident using the elevator as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 09/22/14 during the tour between 2:09 p.m. and 2:45 p.m.</p>	K010160	<p>K 160 NFPA 101 Life Safety Code Standard</p> <p>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 to firefighters service requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Any resident, staff or visitor using</p>	10/22/2014
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	<p>with the Maintenance Supervisor, the elevator equipment rooms located in the basement of the Manor House were provided with sprinkler protection, however, they were not provided with a shunt trip. Based on interview on 09/22/14 concurrent with the observations with the Maintenance Supervisor, it was acknowledged a shunt trip which is designed to automatically disconnect power to the affected elevator, had not been installed in the elevator equipment rooms. Based on the Sprinkler Inspection and Test Report record review on 09/22/14 at 3:25 p.m. with the Maintenance Supervisor, the elevator equipment rooms located in the basement were equipped with sprinkler head protection, however, there was no mention of a shunt trip installation in either room.</p> <p>3.1-19(b)</p>		<p>the elevator could be affected by the alleged deficient practice.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>A quote has been obtained for the installation of the shunts and the work is being scheduled.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>-</p> <p>The elevators are preventatively maintained by an outside vendor who reports any deficiencies to the facility. A new sprinkler/fire vendor was contracted in September and will also monitor the elevator systems.</p> <p>How will the corrective action(s) be monitored to</p>		

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K019999	State Findings	K019999	<p>ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Bi annual and quarterly inspections of the elevator systems are automatically scheduled and reviewed by the maintenance director. The inspection will be added to the facility Preventative Maintenance TEL's system.</p> <p>Any identified concerns from outside vendors will be addressed immediately.</p> <p>The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Compliance Date: 10/22/14</p> <p>K 9999 State Findings</p>	10/10/2014	

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	<p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(a) The facility must be designed, constructed and maintained to protect the health and safety of residents, personnel and the public.</p> <p>This State Rule has not been met as evidenced by: Based on record review and interview; the facility failed to maintain a preventive maintenance program in accordance with the manufacturer's recommendations for cleaning and replacement of battery operated smoke detectors in 96 of 96 resident sleeping rooms. This deficient practice could affect 93 residents in the facility.</p> <p>Findings include:</p> <p>Based on review of "Monthly Smoke Detector Log" with the Maintenance Supervisor during record review from 2:45 p.m. to 3:40 p.m. on 09/22/14, cleaning of battery operated smoke detectors in resident sleeping rooms was not documented for the nine month period of 12/01/13 through 09/01/14. Based on interview at the time of record review, the Maintenance Supervisor stated cleaning of battery operated smoke</p>		<p>3.1-19 Environment and Physical Standards</p> <p>The facility must be designed and constructed and maintained to protect the health and safety of residents, personnel and the public.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>93 residents residing have then the facility had the potential to be affected by the alleged deficient practice.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>The corporate maintenance director inserviced the maintenance staff on documenting the cleaning and</p>	

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	detectors is not performed by the facility and acknowledged documentation of cleaning battery operated smoke detectors in resident rooms was not available for review. 3.1-19(a)		<p>battery replacement of the battery operated smoke detectors in the resident living areas.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>-</p> <p>A log was created for monthly documentation of cleaning and battery replacement of all resident area battery operated smoke detectors. Maintenance department will document 25 random rooms weekly.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The maintenance director will turn in all weekly documentation to the administrator for review. The inspection will be added to the facility Preventative Maintenance</p>		

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			<p>TEL's system.</p> <p>Any identified concerns from audits will be addressed immediately.</p> <p>The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Compliance Date: 10/10/14</p>		