

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155120	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRANDYWINE	STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140
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K 0000 Bldg. 01	<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: 06/02/16</p> <p>Facility Number: 000050 Provider Number: 155120 AIM Number: 100266170</p> <p>At this Life Safety Code survey, Golden Living Center-Brandywine 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 basement was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 128 and had a census of 103 at the time of</p>	K 0000		

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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K 0018 SS=D Bldg. 01	<p>this survey.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had one wooden detached building used for storage which was not sprinkled.</p> <p>Quality Review completed on 06/07/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure the 1 of 113 corridor room doors was provided with a</p>	K 0018	What corrective actions will be accomplished for thoseresidents found to have been affected by the	07/02/2016

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	<p>suitable means for keeping the door closed. This deficient practice affects no residents and staff only who work in the North Hall area near the clean utility room.</p> <p>Findings include:</p> <p>Based on observation with the administrator and maintenance supervisor on 06/02/16 at 11:50 a.m., the North Hall clean utility room door lacked latching hardware and failed to close and latch into the door frame. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/02/16 at 1:30 p.m.</p> <p>3.1-19(b)</p>		<p>deficient practice are as follows:The North hall clean utility roomdoor will have hardware added to provide a suitable means to close and latch toensure the door assembly is able to resist the passage of smoke.</p> <p>How other residents having the potential to be affectedby the same deficient practice will be identified and what corrective actionwill be taken is as follows: Allresidents in a smoke compartment with this deficiency have the potential to beaffected by the same deficient practice. All facility doors will be audited toensure they provide a suitable means to close and latch to ensure the doorassembly is able to resist the passage of smoke. All audits will be completed by 7/2/16.</p> <p>What measures will be put into place or what systemicchanges will be made to ensure that the deficient practice does not recur is asfollows: All facility doors will beaudited five times per week to ensure they to provide a suitable means to closeand latch to ensure the door assembly is able to resist the passage of smoke.This audit will be included in the “Daily interior rounds” section of Building Engines. Any noted deficiency willbe corrected immediately and reported to the ED/designee.</p> <p>How the corrective action will be monitored to ensure thedeficient practice will not recur i.e. what</p>		

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K 0025 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 kitchen ceiling smoke barrier was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 68 residents who use the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p>	K 0025	<p>quality assurance program will be put into place and by what date the systemic changes will be completed is as follows: Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p> <p>By what date the systemic changes will be completed is as follows: 7/2/16</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:The ceiling in the kitchen supervisors office was repaired on June 10, 2016 with sheetrock closing all gaps to ensure at least a ½ hour fire resistance rating in accordance with NFPA 101 life safety code.</p> <p>How other residents having the potential to be affected by the same</p>	07/02/2016
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	<p>Based on observation with the administrator and maintenance supervisor on 06/02/16 at 12:10 p.m., the kitchen supervisor office ceiling had a three foot by five foot rectangular area of drywall detached from the ceiling wooden studs above with a three inch gap into the attic space. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/02/16 at 1:30 p.m.</p> <p>3.1-19(b)</p>		<p>deficient practice will be identified and what corrective action will be taken is as follows: All residents entering this area have potential to be affected by the same deficient practice. The ceiling in the kitchen supervisor's office is to be repaired with sheetrock closing all gaps to ensure at least a ½ hour fire resistance rating in accordance with NFPA 101 life safety code. No other areas identified.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur is as follows: The kitchen manager's office will be inspected by maintenance staff/designee daily x7 days for the period of one week upon repair to ensure there is no further problem with the repair. Inspections of the kitchen area will be conducted quarterly thereafter and recorded in Building Engines. If deficiencies are noted in the inspection they will be repaired as identified.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place and by what date the systemic changes will be completed is as follows: Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends</p>	

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K 0027 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-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 2 of 14 sets of 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 18 residents who reside on the South Advanced Alzheimer Care Unit Hall and 21 residents who reside on the North Advanced Alzheimer Care Unit Hall.</p>	K 0027	<p>identified then will review on PRN basis. Systemic changes will be completed by 7/2/16.</p> <p>By what date the systemic changes will be completed is asfollows: 7/2/16</p> <p>What corrective actions will be accomplished for thoseresidents found to have been affected by the deficient practice are as follows:An astragal will be installed toclose the ½ inch gap in the smoke barrier doors located in the North and Southof the Alzheimers unit in order to resist the passage of smoke. Work to be completed by July 2, 2016.</p> <p>How other residents having the potential to be affectedby the same deficient practice will be identified and what corrective actionwill be taken is as follows: Allresidents on either side of either set of doors in adjacent smoke compartmenthave the potential to be affected by the same deficient practice. An astragalwill be</p>	07/02/2016

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	<p>Findings include:</p> <p>Based on observations on 06/02/16 during a tour of the facility from 9:30 a.m. to 1:30 p.m. with the administrator and maintenance supervisor, the South Advanced Alzheimer Care Unit Hall set of smoke barrier doors and the North Advanced Alzheimer Care Unit Hall set of smoke barrier doors each had a one half inch gap along the center where the doors came together in the closed position. This was verified by the administrator and maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/02/16 at 1:30 p.m.</p> <p>3.1-19(b)</p>		<p>installed to close the ½ inch gap in the smoke barrier doors located in the North and South of the Alzheimers unit in order to resist the passage of smoke. All other doors inspected, no other issues noted.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur is as follows: Smoke doors will be checked five times weekly to ensure proper hardware is in place to ensure the passage of smoke and recorded in the "Daily interior rounds" section of Building Engines. Any deficiency will be reported to the ED/designee immediately and corrected as needed.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place and by what date the systemic changes will be completed is as follows: Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis. Systemic changes will be completed by 7/2/16</p> <p>By what date the systemic changes will be completed is as follows: 7/2/16</p>	

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K 0038 SS=E Bldg. 01	<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 the sidewalk surface on 1 of 14 exit sidewalks was maintained to prevent elevation changes. LSC 7.1.6.2 requires abrupt changes in elevation of the walking surface shall not exceed 1/4 inch. Changes in elevation exceeding 1/4 inch, but not exceeding 1/2 inch shall be beveled 1 to 2. Changes in elevation exceeding 1/2 inch shall be considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice affects 8 residents who use the Administration Hall therapy room.</p> <p>Findings include:</p> <p>Based on observation with the administrator and maintenance supervisor on 06/02/16 at 10:20 a.m., the Administration Hall therapy room exit sidewalk had a one inch elevation change between two concrete sidewalk slabs eight feet from the exit door. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/02/16 at 1:30 p.m.</p>	K 0038	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:The concrete slab near the Administration Hall therapy room exit will be ground down to provide a smooth walkway.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken is as follows:All residents using the Administration Hall therapy room exit walkway have potential to be affected by the same deficient practice. : The concrete slab near the Administration Hall therapy room exit will be ground down to provide a smooth walkway. All other sidewalks inspected, no other issues noted.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur is as follows: All walkways around the exterior of the building will be audited five times weekly and recorded in the "Daily exterior rounds" section of building engines. Any deficient walkway will be reported to the ED/designee and repaired as needed.</p>	07/02/2016	

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K 0046 SS=F Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1. Based on record review and interview, the facility failed to ensure 1 of 1 battery backup light was tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30</p>	K 0046	<p>How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place and by what date the systemic changes will be completed is as follows: Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis. The systemic changes will be put into place no later than 7/2/16.</p> <p>By what date the systemic changes will be completed is as follows: 7/2/16</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows: A functional test of the emergency battery operated lighting at the outside generator set will be conducted at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on the emergency battery operated lighting at the outside generator set for not less than 1 1/2 hours.</p>	07/02/2016

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	<p>seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. 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. 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 any residents in the event of a power outage and the emergency generator location battery backup lighting was needed.</p> <p>Findings include:</p> <p>Based on record review on 06/02/16 at 9:30 a.m. with the administrator and maintenance supervisor, the TELS Weekly and Monthly Generator Logs listed a battery operated emergency light at the outside generator set location but lacked monthly testing indication on the TELS Logs. Based on an interview with the maintenance supervisor on 06/02/16 at 9:45 a.m., when asked if the generator set battery operated emergency light was tested monthly over the past year and an annual 90 minute test conducted, the maintenance supervisor stated the battery</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken is as follows: All residents have the potential to be affected by the same deficient practice. A functional test of the emergency battery operated lighting at the outside generator set will be conducted at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on the emergency battery operated lighting at the outside generator set for not less than 1 1/2 hours.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur is as follows: A functional test of the emergency battery operated lighting at the outside generator set will be conducted at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on the emergency battery operated lighting at the outside generator set for not less than 1 1/2 hours. Results of the testing will be recorded in the "Emergency battery operated lighting" section of BuildingEngines. Any issues noted will be reported to the ED/designee.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place and by what date</p>	

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K 0062 SS=E Bldg. 01	<p>operated emergency light is not tested monthly nor has an annual 90 minute test been conducted over the past year. The lack of a monthly and annual ninety minute test conducted on the emergency generator set battery backup light was verified by the maintenance supervisor at the time of interview and acknowledged by the administrator at the exit conference on 06/02/16 at 1:30 p.m.</p> <p>3.1-19(b)</p> <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>1. Based on record review and interview, the facility failed to ensure a complete flushing program was conducted after an obstruction investigation was conducted on 1 of 1 automatic dry sprinkler piping system which indicated the presence of scale and silt buildup in the sprinkler piping. NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 10-2.3 requires if an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers,</p>	K 0062	<p>the systemic changes will be completed is as follows: Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis. These systemic changes will be completed no later than 7/2/16.</p> <p>By what date the systemic changes will be completed is as follows: 7/2/16</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows: A full system sprinkler flush will be scheduled with a professional sprinkler service company and a letter of intent with the start date of the project will be provided. The bent sprinkler head with the bent deflector in the North Alzheimer's Care Unit Hall janitor closet will be replaced by a professional sprinkler service company. The bed #2 sprinkler head in room</p>	07/02/2016	

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	<p>a complete flushing program shall be conducted. The work shall be done by qualified personnel. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 06/02/16 at 9:50 a.m., the most recent sprinkler system Internal Pipe Inspection from Safecare was dated 08/17/15. Furthermore, the results of the inspection indicated "found large amount of rust build up. System needs complete flush." Based on an interview with the maintenance supervisor on 06/02/16 at 9:55 a.m., when asked if the sprinkler system flushing was conducted as a follow up action to the internal pipe inspection report dated 08/17/15, the maintenance supervisor stated the facility did not have the complete sprinkler flushing conducted. The lack of recommended follow up action taken after the internal pipe inspection of the sprinkler system was verified by the maintenance supervisor at the time of record review and interview and acknowledged by the administrator at the exit conference on 06/02/16 at 1:30 p.m.</p> <p>3.1-19(b)</p>		<p>20which lacked an escutcheon will be repaired with a new escutcheon by a professional sprinkler service company. How other residents having the same deficient practice will be identified and what corrective action will be taken is as follows: All residents have potential to be affected by this deficient practice. A full system sprinkler flush will be scheduled with a professional sprinkler service company and a letter of intent with the start date of the project will be provided. The bent sprinkler head with the bent deflector in the North Alzheimer's Care Unit Hall janitor's closet will be replaced by a professional sprinkler service company. The bed #2 sprinkler head which lacked an escutcheon will be repaired with a new escutcheon by a professional sprinkler service company. All other sprinklers were audited, no other issues noted. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur is as follows: A full facility audit of sprinkler heads and assemblies will be conducted by a professional sprinkler service company by July 2, 2016 to ensure no further deficiencies exist. Any deficiency will be corrected in conjunction with the full sprinkler system flush. How</p>		

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	<p>2. Based on observation and interview, the facility failed to replace 1 of over 300 sprinklers in the facility in the improper orientation. 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 21 residents who reside on the North Advanced Alzheimer Care Unit Hall.</p> <p>Findings include:</p> <p>Based on observation on 06/02/16 at 11:50 a.m. with the administrator and maintenance supervisor, the North Advanced Alzheimer Care Unit Hall janitor closet sprinkler was bent sideways and the deflector was bent sideways. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/02/16 at 1:30 p.m.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview,</p>		<p>the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place and by what date the systemic changes will be completed is as follows: Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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K 0070 SS=E Bldg. 01	<p>the facility failed to ensure 1 of over 300 sprinkler heads in the facility was maintained. This deficient practice could affect 2 residents who reside in resident room 20.</p> <p>Findings include:</p> <p>Based on observation on 06/02/16 at 12:10 p.m. with the administrator and maintenance supervisor, resident room 20, bed #2 sprinkler lacked the sprinkler escutcheon. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/02/16 at 1:30 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 portable space heating devices were prohibited in an area other than a staff area. This deficient practice could affect 39 residents who reside on the North and</p>	K 0070	<p>What corrective actions will be accomplished for thoseresidents found to have been affected by the deficient practice are as follows:1 of 2 portable space heatingdevices or "fire places" which was in the Alzheimer Hall sensory room</p>	07/02/2016

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	<p>South Advanced Alzheimer Halls and all residents who use the Administration Hall sitting room.</p> <p>Findings include:</p> <p>Based on observations on 06/02/16 during a tour of the facility from 9:30 a.m. to 1:30 p.m. with the administrator and maintenance supervisor, the Administration Hall sitting room and the Alzheimer Hall sensory room each had a fake fire place with a portable electric space heating device in use and in the on position with heat coming from the heating vent.</p> <p>This was verified by the administrator and maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/02/16 at 1:30 p.m.</p> <p>3.1-19(b)</p>		<p>was removed from the facility. The second in the Administration hall sitting room was disabled.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken is as follows: All residents utilizing the Advanced Alzheimer's hallways sitting room and sensory room would have the potential to be affected by this deficient practice. 1 of 2 portable space heating devices or "fire places" which was in the Alzheimer Hall sensory room will be removed from the facility. The other portable space heating device located Administration hall sitting room will be disabled.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur is as follows: A full facility audit was performed to ensure that no other portable space heaters are present. Any space heater will be permanently disabled and or removed from the facility. All staff will be in-serviced regarding the use of space heaters.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place and by what date the systemic changes will be completed is as follows: Results of</p>		

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K 0072 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 6 of 14 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on an observations with the administrator and maintenance supervisor on 06/02/16 during a tour of the facility from 9:30 a.m. to 1:30 p.m., the following corridors were obstructed with storage:</p>	K 0072	<p>these audits will be taken to QAPI x 6 months to trackfor any trends. If any trends are identified the audits will be completed basedon QAPI recommendations. If no trends identified then will review on PRN basis.Systemic changes will take place nolater than 7/2/16.</p> <p>By what date the systemic changes will be completed is asfollows: 7/2/16</p> <p>What corrective actions will be accomplished for thoseresidents found to have been affected by the deficient practice are as follows:All items stored in hallways willhave new designated areas outside the means of egress to be stored. No itemswill be stored in the hallways to prevent the obstruction of exits, accessthereto, egress there from, or visibility thereof. Hallways will from thenforth be maintained free of any items whatsoever that would obstruct anyegress.</p> <p>How other residents having the potential to be affectedby the same deficient practice will be identified</p>	07/02/2016	

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	<p>a. The Administration Hall corridor had nine wheel chairs stored in the corridor.</p> <p>b. The North Hall corridor had two wheel chairs and a Hoyer lift stored in the corridor.</p> <p>c. The Main Dining room corridor had four treatment carts stored in the corridor.</p> <p>d. The Back Hall corridor had two soiled linen carts, one trash cart, and a Hoyer lift stored in the corridor.</p> <p>e. The New Wing corridor had five linen carts, one treatment cart, one wooden dresser, and two wheel chairs stored in the corridor. Based on an interview with the administrator and maintenance supervisor on 06/02/16 at 12:45 p.m., the facility uses the corridor to store Hoyer lifts, plastic resident treatment carts, and resident wheel chairs on a routine basis and there is not enough storage rooms to remove these items from the corridors. This was verified by the administrator and maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/02/16 at 1:30 p.m.</p> <p>3.1-19(b)</p>		<p>and what corrective action will be taken is as follows: All residents utilizing any obstructed hallway have the potential to be affected by this deficient practice. All items stored in hallways will have new designated areas outside the means of egress to be stored. No items will be stored in the hallways to prevent the obstruction of exits, access thereto, egress therefrom, or visibility thereof. Hallways will from then forth be maintained free of any items whatsoever that would obstruct any egress.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur is as follows: All staff will be inserviced to ensure all employees know the hallways are to be free from all obstruction and that they know the new locations where items are to be stored properly. Maintenance will observe during their "Daily interior rounds" any obstructions and report to the Management in morning meeting if any obstruction exists. Management will ensure that the obstruction is removed as noted. This observation will be recorded in the "Daily interior rounds" section of Building Engines.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will</p>	

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			<p>beput into place and by what date the systemic changes will be completed is as follows:Results of these audits will be taken to QAPI x 6 months to track for anytrends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis. Systemic changes will be completed no later than 7/2/16.</p> <p>By what date the systemic changes will be completed is as follows: 7/2/16</p>		