

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/18/2014
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NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
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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: 09/18/14</p> <p>Facility Number: 000501 Provider Number: 155635 AIM Number: 100266260</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Grace Village Health Care Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building consisting of halls 1, 2, 3, 5 and the main dining room was surveyed with Chapter 19 Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type III (211) construction and was partially sprinklered. The facility has a fire alarm system with smoke detection in corridors and in areas open to the</p>	K010000	Submission and implementation of this plan of correction shall not constitute an admission by Grace Village Health Care to any allegations of deficiency as stated in the "Summary Statement of Deficiencies" or an agreement with any conclusions made therein. Rather, this plan is submitted in accordance with State and Federal requirements.	
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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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K010021 SS=D	<p>corridors. Battery operated smoke detectors were installed in all resident rooms in the original building. The facility has a capacity of 89 and had a census of 76 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered included a detached garage used for storage of maintenance equipment and parts with the portion of the building used as a maintenance garage, and a detached shed used for storage of parts and lawn equipment. The facility had a fire pump room that was sprinklered.</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 Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p>			

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	<p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 9 sets of horizontal exit smoke barrier doors were held open only by a device which would allow it to close automatically upon activation of the fire alarm system. This deficient practice could affect 4 of 7 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with Maintenance Technician #8 on 09/18/14 at 1:25 p.m., the smoke barrier doors entering Hall 3 were manually released and held in the open position by a medication card. Maintenance Technician #8 acknowledged and moved the medication cart. At 3:08 p.m., the smoke barrier door set entering the main dining room from Hall 2 were manually released and held in the open position by a plastic wheeled walker. Maintenance Technician #8 acknowledged and moved the plastic wheeled walker. At 3:40 p.m., the smoke barrier door set entering Hall 3 were again manually released and held in</p>	K010021	<p>I. CORRECTIVE ACTION: No residents were identified as having been affected by the cited deficiency. As noted, the objects that prevented the smoke barrier doors from fully closing were moved immediately. II. OTHER RESIDENTS IDENTIFIED: The report indicates that all residents of the units could have been affected. No residents were actually affected. The objects preventing the doors from fully closing were removed immediately when identified. III. SYSTEMIC CHANGES/ PREVENTATIVE MEASURES: The facility is setup with the proper technology and hardware to comply with Code as the doors did release from their magnetically held position when activated. The objects that prevented the doors from fully closing were various pieces of equipment in use by staff for the purpose of providing care and services to residents. The objects were not intentionally placed to hold the smoke barrier doors open but were unfortunately placed too closely to the doors during the time the testing took</p>	10/18/2014

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K010038 SS=E	the open position by a portable lift. Maintenance Technician #8 acknowledged and moved the portable lift. 3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD		place. To ensure equipment is not placed too closely to smoke barrier doors, current direct care staff will be in-serviced on acceptable locations to temporarily set equipment that is being used as they carry out their duties. In addition, new staff will also receive this specific instruction during their orientation time. IV. MONITORING THE CORRECTIONS FOR EFFECTIVENESS: A log sheet will be implemented and a member of the Environmental Services team will utilize it to document periodic inspections of the corridors to ensure compliance with proper placement of equipment. Inspections will be conducted weekly for 3 months then monthly for 3 months provided there are no compliance problems observed. The results will be presented to the QA Committee for review on a quarterly basis. Failure to achieve 100% compliance will result in extending the inspection period and retraining and potentially disciplinary action for any staff member found to be responsible for non-compliant equipment placement. The QA Committee will determine if additional corrective actions are necessary based upon the inspection reports.		

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K010056 SS=E	<p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 exit discharge paths was readily accessible at all time in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for buildings shall comply with Chapter 7. LSC Section 7.2.5.4 requires a ramp with a rise greater than 6 inches shall have handrails. LSC Section 7.2.2.4.2 Exception #3 states existing ramps shall be permitted to have a handrail on one side only. This deficient practice could affect residents evacuated through the Hall 5 exit near the main dining room.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Technician #8 on 09/18/14 at 2:15 p.m., the Hall 5 exit discharge sidewalk/ramp lacked a handrail on the ramp. Based on an interview with Maintenance Technician #8 at the time of observation, he confirmed the rise from the building to the street level was approximately five feet.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K010038	<p>I. CORRECTIVE ACTION: No specific residents were identified as having been affected. II. OTHER RESIDENTS IDENTIFIED: No other residents were identified as having been affected. III. SYSTEMIC CHANGES/ PREVENTATIVE MEASURES: New reflective signage will be permanently mounted to clearly designate the evacuation route to the public way via the level sidewalk rather than the ramp which could otherwise be mistaken as the evacuation route.IV. MONITORING:The Director of Environmental Services, or his designee, will inspect the signage on a monthly basis to ensure it remains clearly visible and in good functioning capacity. The results of the monitoring will be reported to the QA Committee on a quarterly basis. The committee will recommend that monitoring be discontinued after at least six months of continual compliance without incident. If any compliance problems are found, the committee will review and make recommendations on additional corrective actions.</p>	12/01/2014			

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	<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 complete automatic sprinkler system was provided for 1 of 1 attic areas and 1 of 1 Human Resources office closet in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice could affect 49 residents in the healthcare building.</p> <p>Findings include:</p> <p>Based on an observation with Maintenance Technician #8 on 09/18/14 from 1:11 p.m. to 4:15 p.m., the closet in the Human Resources office and the attic above Hall 3, main nurses' station, Hall 1 and the hallway entering healthcare from the rehabilitation entrance lacked sprinkler coverage. Each area was</p>	K010056	<p>I. CORRECTIVE ACTION: No residents were identified to have been affected. II. OTHER RESIDENTS IDENTIFIED: No other residents were identified to have the potential to be affected. III. SYSTEMIC CHANGES / PREVENTATIVE MEASURES: The facility's sprinkler system contractor will install a dry system in the attic space according to the requirements of NFPA 13. (Please see the attached contract with the sprinkler contractor and the attached outline of the dates by which the system will be installed.) IV. MONITORING: The new components of the sprinkler system will be inspected on the same frequency and by the same contractor who currently inspects and maintains the existing components according to NFPA 25. The Director of Environmental Services will indicate on his electronic calendar the due dates</p>	12/15/2014

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K010064 SS=B	<p>acknowledged by Maintenance Technician at the time of observations.</p> <p>3.1-19(b)</p> <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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire pump room portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. This deficient practice could affect any resident, staff and/or visitors.</p> <p>Findings include:</p> <p>Based on observation and interview with Maintenance Technician #8 on 09/18/14 at 12:27 p.m., he acknowledged the</p>	K010064	<p>of inspections that will provide automatic reminders in addition to the routine inspection system that the contractor will maintain. If any inspections are not completed by a due date, it will be reported to the QA Committee, which will determine if additional monitoring actions are needed.</p> <p>I. CORRECTIVE ACTIONS: No specific residents, staff or visitors were identified to have been affected by the cited deficiency. II. OTHER RESIDENTS IDENTIFIED: No residents, staff or visitors who had the potential to be affected by the cited deficiency were actually affected. III. SYSTEMIC CHANGES / PREVENTATIVE MEASURES: The fire extinguisher located in the pump house was serviced and tagged. This extinguisher had gotten missed for inclusion on the extinguisher check log sheet. It has been added to the log sheet. Environmental Services department will conduct an audit of the facilities to ensure no other extinguishers have been missed on the log sheet. Director of Environmental Services has added annual inspection due date to electronic calendar for automatic reminders of future due dates of annual maintenance on</p>	10/18/2014

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K010066 SS=C	<p>annual service and inspection tag for the portable fire extinguisher located in the fire pump room occurred on July 2013 and must have been missed during the 2014 annual service inspections.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied</p>		<p>all fire extinguishers.IV. MONITORING:Director of Environmental Services, or his designee, will conduct monthly checks of the inspection logs for a minimum of 6 months to ensure all required inspections have been completed. Results of the inspections will be reported to the QA Committee quarterly. If less than 100% compliance is achieved, the Committee will require monitoring to continue until at least 3 consecutive months of 100% compliance is demonstrated and may recommend additional corrective measures.</p>		

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	<p>are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to enforce 1 of 1 smoking policies for the facility. The cigarette butts were on the ground near the emergency generator therefore this deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on an observation with Maintenance Technician #8 on 09/18/14 at 12:18 p.m., there were at least thirty five cigarette butts on the ground near the emergency generator. Based on an interview with Maintenance Technician #8 at the time of observation, the entire campus is designated smoke free.</p> <p>3.1-19(b)</p>	K010066	<p>I. CORRECTIVE ACTION: No specific residents were found to have been affected. II. OTHER RESIDENTS IDENTIFIED: No other residents have been identified to have the potential to be affected. III. SYSTEMIC CHANGES / PREVENTATIVE MEASURES: Facility policy states that smoking is prohibited on the premises except for inside one's personal vehicle. Metal receptacles will be placed in the areas where cigarette butts have been found on the ground. Signs encouraging the use of the receptacles will be posted. IV. MONITORING: The Director of Environmental Services, or his designee, will conduct inspections of the grounds around the affected area on a weekly basis for at least one month and then monthly for at least six months to ensure that the policy is followed and the metal containers are effective in controlling the proper disposal of cigarette butts. The results of inspections will be reported to the quarterly QA Committee. Monitoring may cease after six months provided no issues with compliance are found. If non-compliance with the use of the provided containers and the signage is found, the QA Committee will review and make further recommendations of correction and monitoring.</p>	12/05/2014

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in 1 of 5 fire barrier walls and 1 of 1 elevator equipment rooms were maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is</p>	K010130	<p>I. CORRECTIVE ACTION: No specific residents were identified as having been affected by this deficiency. II. OTHER RESIDENTS IDENTIFIED: No other residents were identified to have been potentially affected by the sited deficiency. III. SYSTEMIC CHANGES / PREVENTATIVE MEASURES: Facility maintenance technicians filled all of the identified penetrations with an approved fire barrier sealant. All other fire barriers were inspected to ensure no other unsealed penetrations were present. All facility maintenance technicians will be given an in-service on the requirement of fire barrier sealant for all penetrations of a fire barrier in accordance with LSC 8.2.3.2.4.2 IV. MONITORING: The Director of Environmental Services, or his designee, will conduct an inspection of all job sites on or near fire barriers to ensure that any new penetrations have been properly sealed. These inspections will be conducted monthly for a minimum of 6 months. He will report the results of his inspections to the QA Committee which meets on a quarterly basis. Anything less than 100% compliance will result in an extended monitoring period and the QA Committee will determine if additional corrective</p>	10/18/2014	

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K010147 SS=D	<p>capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect residents in 3 of 7 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with Maintenance Technician #8 on 09/18/14 at 3:00 p.m., two of eight penetrations measuring one half inch in the block wall surrounding the elevator equipment room were not sealed with firestop. Above the ceiling tile at 3:30 p.m., a one inch unsealed penetration was observed in the fire barrier wall entering Hall 2 from the main dining room. Measurements were provided by Maintenance Technician #8 at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and</p>	K010147	<p>measures are necessary.</p> <p>I. CORRECTIVE ACTION: No specific residents were identified to have been affected by the cited deficiency. II. OTHER RESIDENTS IDENTIFIED: No other residents identified to have</p>	10/18/2014			

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	<p>equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not a resident care area but could affect facility maintenance staff.</p> <p>Findings include:</p> <p>Based on an observation and interview with Maintenance Technician #8 on 09/18/14 at 2:35 p.m., he acknowledged there was a heavy duty extension cord plugged in and provided power to a cable splitter in the Hall 5 mechanical room.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a patient care area but could affect facility staff in the medication room at the Hall 5 nurses' station.</p>		<p>been potentially affected by the cited deficiency were actually affected. III. SYSTEMIC CHANGES / PREVENTATIVE MEASURES: Permanent wiring enclosed in conduit was installed to power the cable splitter in the Hall 5 mechanical room. A new electric receptacle was installed in the Hall 5 medication room to accommodate the location of the refrigerator without utilizing an extension cord power strip.</p> <p>Environmental Services staff will be in-serviced on the topic that wiring in all areas must be fixed according to NFPA 70, and they, as well as Nursing staff will be in-serviced that power strips are not permitted to supply power to high current draw equipment. IV. MONITORING: The same log sheet implemented to monitor placement of equipment in corridors will be used by a member of the Environmental Services team to document periodic inspections of mechanical rooms and utility areas to ensure that non-fixed wiring is not in use where not permitted. Inspections will be conducted weekly for at least 6 months and the results will be presented to the QA Committee for review on a quarterly basis.</p> <p>Failure to achieve 100% compliance will result in extending the inspection period and retraining and potentially disciplinary action for any staff member found to be responsible</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/18/2014
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K030000	<p>Findings include:</p> <p>Based on an observation with Maintenance Technician #8 on 09/18/14 at 2:58 p.m., a refrigerator was plugged into an extension cord power strip in the Hall 5 medication room. This was acknowledged by Maintenance Technician #8 at the time of observation.</p> <p>3.1-19(b)</p> <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: 09/18/14</p> <p>Facility Number: 000501 Provider Number: 155635 AIM Number: 100266260</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist,</p> <p>At this Life Safety Code survey, Grace Village Health Care Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from</p>	K030000	<p>for non-compliant use of extension cords or power strips. The QA Committee will determine if additional corrective actions are necessary based upon the inspection reports.</p> <p>Submission and implementation of this plan of correction shall not constitute an admission by Grace Village Health Care to any allegations of deficiency as stated in the "Summary Statement of Deficiencies" or an agreement with any conclusions made therein. Rather, this plan is submitted in accordance with State and Federal requirements.</p>	

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	<p>Fire, the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The Rehabilitation hall and Therapy was surveyed with Chapter 18 New Health Care Occupancies.</p> <p>The Rehabilitation addition to the facility, completed in 2007, was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and in areas open to the corridors. The new Rehabilitation Unit had hard wired smoke detectors in resident rooms. The facility has a capacity of 89 and had a census of 76 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered included a detached garage used for storage of maintenance equipment and parts with the portion of the building used as a maintenance garage, and a detached shed used for storage of parts and lawn equipment. The facility had a fire pump room that was sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the</p>			

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K030066 SS=C	<p>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 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. 18.7.4</p> <p>Based on observation and interview, the facility failed to enforce 1 of 1 smoking policies for the facility. The cigarette butts were on the ground near the emergency generator therefore this deficient practice could affect all occupants.</p>	K030066	I. CORRECTIVE ACTION: No specific residents were found to have been affected. II. OTHER RESIDENTS IDENTIFIED: No other residents have been identified to have the potential to be affected. III. SYSTEMIC CHANGES / PREVENTATIVE MEASURES: Facility policy states that smoking is prohibited on the	12/05/2014
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	<p>Findings include:</p> <p>Based on an observation with Maintenance Technician #8 on 09/18/14 at 12:18 p.m., there were at least thirty five cigarette butts on the ground near the emergency generator. Based on an interview with Maintenance Technician #8 at the time of observation, the entire campus is designated smoke free.</p> <p>3.1-19(b)</p>		<p>premises except for inside one's personal vehicle. Metal receptacles will be placed in the areas where cigarette butts have been found on the ground. Signs encouraging the use of the receptacles will be posted. IV. MONITORING: The Director of Environmental Services, or his designee, will conduct inspections of the grounds around the affected area on a weekly basis for at least one month and then monthly for at least six months to ensure that the policy is followed and the metal containers are effective in controlling the proper disposal of cigarette butts. The results of inspections will be reported to the quarterly QA Committee. Monitoring may cease after six months provided no issues with compliance are found. If non-compliance with the use of the provided containers and the signage is found, the QA Committee will review and make further recommendations of correction and monitoring.</p>		