

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/27/2013
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NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
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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: 11/27/13</p> <p>Facility Number: 000131 Provider Number: 155226 AIM Number: 100274910</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, North Capitol Nursing & Rehabilitation Center 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 four story facility was determined to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors</p>	K010000	<p>We are requesting a face to face IDR for K038. The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests that the 2567 PLAN OF CORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION AND REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEY RE-VISIT on or after 12.27.13.</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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	<p>hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 123 and had a census of 96 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/02/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010014 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to provide documentation of the flame spread rating for interior finish materials installed in 1 of 3 first floor exitways. This deficient practice could affect 26 residents, staff or visitors.</p> <p>Findings include:</p> <p>Based on observation with the Assistant Maintenance Superintendent during a tour of the facility from 12:30 p.m. to 4:00 p.m. on 11/27/13, two walls of the main entrance foyer on the first floor had wood paneling installed on each wall from the floor to four feet high on the wall. Based on interview at the time of observation, the Assistant Maintenance Superintendent stated none of the main entrance foyer walls had been treated with flame retardant material and acknowledged flame spread rating documentation was not available for review for the wood paneling installed at the aforementioned location.</p> <p>3.1-19(b)</p>	K010014	<p>It is the practice of this provider to ensure interior finish for corridors and exit ways have a flame spread rating of Class A or Class B. What corrective action will be accomplished for those residents found to have been affected? The wood paneling installed will be treated with a flame retardant material. How other residents will be identified and what correction action taken? All areas with wood paneling that has not been treated with flame retardant material will be identified through inspection by the maintenance supervisor or designee. What systemic changes will be made to ensure the deficient practice does not recur? Future projects that involve wood paneling will be identified prior to installation. Material with flame spread rating of Class A or Class B will be utilized. How the corrective action will be monitored? An environmental CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by the maintenance supervisor/designee. The</p>	12/27/2013			

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			environmental audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. Date of compliance: 12.27.2013	

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K010015 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to provide documentation of the flame spread rating for interior finish materials installed in 2 of over 120 rooms. This deficient practice could affect 26 residents, staff or visitors.</p> <p>Findings include:</p> <p>Based on observations with the Assistant Maintenance Superintendent during a tour of the facility from 12:30 p.m. to 4:00 p.m. on 11/27/13, all four walls of the second floor Nurses Office and the third floor Nurses Station by Room 301 had wood paneling installed on the entire wall from floor to ceiling. Based on interview at the time of the observations, the Assistant Maintenance Superintendent stated none of the walls had been treated with flame retardant material and acknowledged flame spread rating documentation was not available for</p>	K010015	<p>It is the practice of this provider to ensure interior finish for rooms and spaces not used for corridors or exit ways, have a flame spread rating of Class A or Class B. What corrective action will be accomplished for those residents found to have been affected? The wood paneling installed in the second floor Nurses office and the third floor nurses station will be treated with a flame retardant material. How other residents will be identified and what correction action taken? All areas with wood paneling that has not been treated with flame retardant material will be identified through inspection by the maintenance supervisor or designee. What systemic changes will be made to ensure the deficient practice does not recur? Future projects that involve wood paneling will be identified prior to installation. Material with flame spread rating of Class A or Class B will be utilized. How the corrective action will be monitored? An</p>	12/27/2013	

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	review for the wood paneling installed at the aforementioned locations. 3.1-19(b)		environmental CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by the maintenance supervisor/designee. The environmental audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. Date of compliance: 12.27.2013		

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>1. Based on observation and interview, the facility failed to ensure ensure 2 of 4 ceiling smoke barriers were maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 10 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Assistant Maintenance Superintendent during a tour of the facility from 12:30 p.m. to 4:00 p.m. on 11/27/13, the following openings in the ceiling smoke barrier on the first and third floor were noted which exposed the underside of the untreated floor deck above:</p> <p>a. a three foot by two foot opening in the ceiling of the storage room in the first floor Activities Room.</p> <p>b. the first floor Alarm Panel Mechanical Room ceiling had two, four inch diameter</p>	K010025	<p>It is the practice of this provider to ensure smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. What corrective action will be accomplished for those residents found to have been affected? All identified areas will be sealed in accordance with 8.3. How other residents will be identified and what correction action taken? A facility inspection will be performed by the maintenance director or designee to ensure there are no other areas that do not provide at least a lone half hour fire resistance rating in accordance with 8.3. If identified, these areas will immediately be repaired by maintenance/designee. What systemic changes will be made to ensure the deficient practice does not recur? Weekly inspection will be completed to monitor for breaches in smoke barriers. Deficiencies found will</p>	12/27/2013	

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	<p>holes above the main fire panel, three three inch in diameter holes above the electrical panel for ten electrical conduits and an eight inch by six inch rectangular opening above the "150 amp EM1 Panel."</p> <p>c. a four inch in diameter hole for 30 cables and a three inch in diameter hole for 20 cables in the ceiling of the TV Room in the service corridor.</p> <p>d. a six foot by three foot opening in the ceiling of the emergency generator room.</p> <p>e. a three foot by three foot opening of the ceiling of the first floor riser room next to the elevator machine room.</p> <p>f. a two inch in diameter hole in the ceiling of the Employee Restroom by the third floor Nurses' Station by the Memory Care Facilitator's Office.</p> <p>Based on interview at the time of the observations, the Assistant Maintenance Superintendent acknowledged the aforementioned openings in the ceiling smoke barrier on the first and third floor did not provide at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure openings through 2 of 6 smoke barrier walls on the first floor were protected to maintain the smoke resistance of the smoke barrier. This deficient practice could affect 5 staff</p>		<p>immediately by corrected by the maintenance director or designee. How the corrective action will be monitored? An environmental CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by the maintenance supervisor/designee. The environmental audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. Date of compliance: 12.27.2013</p>				

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	<p>and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Assistant Maintenance Superintendent during a tour of the facility from 12:30 p.m. to 4:00 p.m. on 11/27/13, the following openings in first floor smoke barrier walls were noted:</p> <p>a. an eight inch by three inch hole in the wall of the Housekeeping Office in the service corridor through which a two inch in diameter sprinkler pipe passed through into an adjoining storage room was not smoke resistant.</p> <p>b. a two inch in diameter hole and a one inch annular space surrounding a one foot by two foot duct passing through the north wall of the elevator machine room by the riser room was not smoke resistant.</p> <p>Based on interview at the time of the observations, the Assistant Maintenance Superintendent acknowledged the aforementioned openings in first floor smoke barrier walls failed to maintain the smoke resistance of the smoke barrier.</p> <p>3.1-19(b)</p>						

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K010027 SS=E	<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 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 sets of smoke barrier doors on the second floor would close to form a smoke resistant barrier. Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors which swing in the same direction and are equipped with an astragal to have a coordinator to ensure the door which must close first, always closes first. This deficient practice could affect 24 residents, staff and visitors in vicinity of the smoke barrier doors by Room 225 if smoke was allowed to move from one smoke compartment to another.</p> <p>Findings include:</p> <p>Based on observation with the Assistant Maintenance Superintendent during a tour of the facility from 12:30 p.m. to 4:00 p.m. on 11/27/13, the set of smoke barrier doors in the corridor by Room 225 swing</p>	K010027	It is the practice of this provider to ensure door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 ¼ inch thick solid bonded wood core. What corrective action will be accomplished for those residents found to have been affected? The coordinator on the identified door will be adjusted or replaced. How other residents will be identified and what correction action taken? A facility inspection will be performed by the maintenance director or designee to ensure there are no other smoke barrier doors that are not closing properly. If identified, these areas will immediately be repaired by maintenance/designee. What systemic changes will be made to ensure the deficient practice does not recur? Weekly inspections will be completed to ensure the smoke barrier doors are properly closing. Deficiencies will be repaired immediately. How the	12/27/2013	

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	<p>in the same direction, are equipped with an astragal and a door closing coordinator but the door closing coordinator did not function when the smoke barrier door set was manually closed five times which did not ensure the door equipped with an astragal closes last and forms a smoke resistant barrier. Based on interview at the time of observation, the Assistant Maintenance Superintendent acknowledged the aforementioned second floor smoke barrier door set did not close completely because the door closing coordinator was not functioning to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier.</p> <p>3.1-19(b)</p>		<p>corrective action will be monitored? An environmental CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by the maintenance supervisor/designee. The environmental audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. Date of compliance: 12.27.2013</p>		

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K010038 SS=E	<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 means of egress through 8 of 12 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect 70 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Assistant Maintenance Superintendent during a tour of the facility from 12:30 p.m. to 4:00 p.m. on 11/27/13, the Main Dining Room exit on the first floor, each of three stairwell access doors on the second and fourth floors and the third floor stairwell exit by the Director of Nursing Services</p>	K010038	<p>We are requesting a face to face IDR related to this deficiency based on Exception No. 1 "door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided staff can readily unlock such doors at all times." It is the practice of this provider to ensure exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1.</p> <p>What corrective action will be accomplished for those residents found to have been affected? The code will be posted on doors of egress leading to the stairs on units where the residents' safety and security will not be compromised. How other residents will be identified and what correction action taken? A facility inspection will be performed by the maintenance director or designee to ensure there are no other areas where the exit access is not readily accessible at all times in accordance with section 7.1. If identified, these areas will immediately be addressed by maintenance/designee. What</p>	12/27/2013			

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	<p>Office were each marked as a facility exit, each exit door was magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview with the Assistant Maintenance Superintendent, it was acknowledged the four digit code was not posted at each of the aforementioned facility exits. Based on interview during the exit conference at 4:15 p.m. on 11/27/13, the Executive Director stated residents who have a clinical diagnosis to be in a secure building are housed only in the Memory Care area of the third floor and acknowledged the exit access code was not posted at the aforementioned exit access doors located on floors other than the third floor Memory Care area. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.</p> <p>3.1-19(b)</p>		<p>systemic changes will be made to ensure the deficient practice does not recur? Weekly inspections will be completed to ensure the exit access is readily accessible in accordance with section 7.1. How the corrective action will be monitored? An environmental CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by the maintenance supervisor/designee. The environmental audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. Date of compliance: 12.27.2013</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 and interview, the facility failed to replace 2 of over 100 sprinklers in the facility which had become corroded or had paint on them. 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 50 residents, staff and visitors in the vicinity of the second floor Dining Room.</p> <p>Findings include:</p> <p>Based on observations with the Assistant Maintenance Superintendent during a tour of the facility from 12:30 p.m. to 4:00 p.m. on 11/27/13, the automatic sprinkler located on the ceiling in the main laundry room behind the dryers had become green with corrosion and the automatic sprinkler located in the second floor</p>	K010062	<p>It is the practice of this provider to ensure required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. What corrective action will be accomplished for those residents found to have been affected? The identified sprinkler heads will be replaced by fire suppression company. How other residents will be identified and what correction action taken? A facility inspection will be performed by the maintenance director or designee to ensure there are no other issues with the automatic sprinkler system's operability. If identified, these areas will immediately be addressed by maintenance/designee. What systemic changes will be made to ensure the deficient practice does not recur? Weekly inspections will be completed to ensure the automatic sprinkler system is maintained in reliable operating condition. How the corrective action will be monitored? An environmental CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly</p>	12/27/2013			

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	Dining Room by the entry door was entirely covered with white paint. Based on interview at the time of the observations, the Assistant Maintenance Superintendent acknowledged the aforementioned automatic sprinklers were corroded or entirely covered with paint. 3.1-19(b)		for two months, and then monthly for three months by the maintenance supervisor/designee. The environmental audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. Date of compliance: 12.27.2013	

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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</p> <p>Based on observation and interview, the facility failed to inspect 2 of 32 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious physical damage or condition to prevent its operation. This deficient practice could affect 12 residents, staff and visitors in the vicinity of the third floor Nurses Station by the Memory Care Facilitator's Office.</p> <p>Findings include:</p> <p>Based on observations with the Assistant Maintenance Superintendent during a tour of the facility at 12:30 p.m. to 4:00 p.m. on 11/27/13, the following was noted:</p>	K010064	It is the practice of this provider to ensure portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. What corrective action will be accomplished for those residents found to have been affected? The identified portable fire extinguishers were inspected, and will be inspected monthly hereafter. How other residents will be identified and what correction action taken? A facility inspection will be performed by the maintenance director or designee to ensure all portable fire extinguishers are inspected monthly. If deficiencies identified, these areas will immediately be addressed by maintenance/designee. What systemic changes will be made to ensure the deficient practice does not recur? Weekly inspections will be completed to ensure the portable fire extinguishers are inspected on a monthly basis. How the corrective action will be monitored? An environmental CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by the maintenance supervisor/designee. The environmental audit tool will be	12/27/2013			

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	<p>a. the maintenance tag attached to the portable fire extinguisher located at the third floor Nurses Station by the Memory Care Facilitator's Office indicated a monthly inspection was not documented for September and October 2013.</p> <p>b. the maintenance tag attached to the portable fire extinguisher located in the first floor elevator machine room in the Activity Room indicated a monthly inspection was not documented for February through October 2013. Based on interview at the time of the observations, the Assistant Maintenance Superintendent stated no other monthly fire extinguisher inspection documentation was available for review and acknowledged a monthly inspection for the aforementioned portable fire extinguisher locations was not documented for the aforementioned months in 2013.</p> <p>3.1-19(b)</p>		<p>reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. Date of compliance: 12.27.2013</p>		

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K010103 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure interior walls in 3 of over 100 rooms in the facility were comprised of noncombustible or limited combustible materials. LSC 19.1.6.3 states all interior walls and partitions in buildings of Type I or Type II construction shall be of noncombustible or limited combustible materials.</p> <p>Exception: Listed, fire retardant treated wood studs shall be permitted within non-load bearing 1 hour fire rated partitions. This deficient practice could affect 16 residents, staff and visitors in the vicinity of the third floor Dining Room.</p> <p>Findings include:</p> <p>Based on observations with the Assistant Maintenance Superintendent during a tour of the facility from 12:30 p.m. to 4:00 p.m. on 11/27/13, exposed wood studs comprised the frame of non-load bearing interior walls constructed at the following locations were noted:</p> <p>a. two walls of the electric furnace room inside the third floor Dining Room. b. a ten foot long by eighteen inch high</p>	K010103	<p>It is the practice of this provider to ensure interior walls and partitions in building of Type I or Type II construction are noncombustible or limited-combustible materials.</p> <p>What corrective action will be accomplished for those residents found to have been affected? The identified areas will be replaced with metal studs. How other residents will be identified and what correction action taken? A facility inspection will be performed by the maintenance director or designee to ensure there are no exposed wood studs. If deficiencies identified, these areas will immediately be addressed by maintenance/designee. What systemic changes will be made to ensure the deficient practice does not recur? Weekly inspections will be completed to ensure there are no exposed wood studs. How the corrective action will be monitored? An environmental CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by the maintenance supervisor/designee. The environmental audit tool will be</p>	12/27/2013			

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	<p>wall above the dryers in the laundry.</p> <p>c. the north wall of the first floor elevator machine room which separated the riser room from the elevator machine room.</p> <p>The exposed wood studs at each of the aforementioned locations did not have the fire retardant status of the studs stamped or labeled on the wood. Based on interview at the time of the observations, the Assistant Maintenance Superintendent stated no other fire retardant documentation for the wood studs was available for review and acknowledged the aforementioned non-load bearing walls were not constructed of noncombustible or limited combustible materials.</p> <p>3.1-19(b)</p>		<p>reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. Date of compliance: 12.27.2013</p>	

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K010147 SS=E	<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>Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. 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 could affect 12 residents, staff and visitors in the vicinity of the Therapy Room on the fourth floor.</p> <p>Findings include:</p> <p>Based on observations with the Assistant Maintenance Superintendent during a tour of the facility at 11:00 a.m. on 11/27/13, a refrigerator and a coffee pot were plugged into a power strip in the storage room for the Therapy Room on the fourth floor. In addition, based on observation with the Assistant Maintenance Superintendent at 3:30 p.m. on 11/27/13, a refrigerator and a microwave oven were plugged into a power strip in the Housekeeping Office in the service corridor on the first floor. Based on interview at the time of the observations, the Assistant Maintenance Superintendent acknowledged power strips were in use as a substitute for fixed</p>	K010147	<p>It is the practice of this provider to ensure electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. What corrective action will be accomplished for those residents found to have been affected? The identified areas will be corrected by ensuring the electrical equipment is plugged directly into a power source. How other residents will be identified and what correction action taken? A facility inspection will be performed by the maintenance director or designee to ensure there are no electrical violations. If deficiencies identified, these areas will immediately be addressed by maintenance/designee. What systemic changes will be made to ensure the deficient practice does not recur? Weekly inspections will be completed to ensure there are no electrical violations. How the corrective action will be monitored? An environmental CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by the maintenance supervisor/designee. The environmental audit tool will be reviewed monthly by the CQI</p>	12/27/2013			

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	wiring at the aforementioned locations. 3.1-19(b)		committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. Date of compliance: 12.27.2013		