

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/30/2014
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NAME OF PROVIDER OR SUPPLIER  FAIRMONT REHABILITATION CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/30/14</p> <p>Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Fairmont Rehabilitation Center, LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the</p>	K010000	By submitting the enclosed information we are not admitting the truth of accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the Plan of Correction be considered our allegation of Compliance to the state finding of the survey completed January 30, 2014.	

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>corridors and battery operated detectors in all resident sleeping rooms. The facility has a capacity of 105 and had a census of 58 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except for the walk-in cooler in the kitchen, one detached garage and the one detached rental pod which provided facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/17/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 8 doors to hazardous areas such as the kitchen would self close and latch securely into the frame. This deficiency could affect 10 or more residents on 300 south hall, which is adjacent to the kitchen as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/30/14 at 1:45 p.m. with the Maintenance Supervisor, the door which separates the kitchen from the Main dining room adjacent to 300 south hall did not latch into the door frame since it was not provided with a latching device. Based on interview on 01/30/14 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned</p>	K010029	<p>Corrective ActionThe door that seperates the kitchen from the dining room will have a latching device installed on the door. IdentificationResidents that are in the dining room have the potential to be affected. System ChangesAll doors to hazardous areas will be audited to assure each has a self closer and latches securely into the frame. MonitoringMaintenance Supervisor/designee will check doors to hazardous areas monthly for 12 months to assure latching to the frame. Any identified issues/concerns/problems will be reported to the QA Committee for further discussion/review and recommendations.</p>	02/28/2014			

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K010048 SS=F	<p>kitchen door lacked any latching hardware and therefore could not be kept closed and secured to the door frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to include the use of the "ABC" and "K" fire extinguisher in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety pan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all residents in the facility as well as staff and visitors.</p>	K010048	<p>Corrective ActionThe written fire safety plans now include the use of "ABC" and "K" extinguishers in the event of an emergency. IdentificationResident s would have the potential to be affected. System ChangesThe policy that addresses the use of fire extinguishers has been updated to include "ABC" and "K" extinguishers. All staff will be inserviced on the change in the policy. MonitoringThe administrator/designee will audit fire safety plans monthly for one year to assure policy is in place.</p>	02/28/2014

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	<p>Findings include:</p> <p>a. Based on a review of the facility's written Fire and Disaster Plan on 01/30/14 at 3:05 p.m. with the Maintenance Supervisor, the fire disaster plan did not include the use and location of the fire extinguishers including the K-class and ABC fire extinguishers located in the kitchen in relationship with the use of the kitchen overhead extinguishing system, and use of the ABC extinguishers throughout the facility as all purpose extinguisher. Based on an interview on 01/30/14 at 3:07 p.m. with the Maintenance Supervisor, it was acknowledged the written fire safety plan for the facility did not include mention of the K-class or the ABC fire extinguishers.</p> <p>b. Based on review of the facility's Fire and Disaster Plan provided by the Maintenance Supervisor on 01/30/14 at 3:10 p.m., the plan did not address all components of LSC 19.7.2.2 such as the evacuation of the immediate area and the evacuation of the smoke compartment. Based on interview at the time of record review, it was acknowledged by the Maintenance Supervisor, the facility's Fire and Disaster Plan did not address an internal evacuation of residents from the affected area to another smoke compartment</p>						

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K010050 SS=F	<p>behind a smoke or fire wall.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to conduct fire drills on all shifts for 1 of 4 quarters for 2013. This deficient practice affects all residents in the facility including staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Monthly Fire Drill records on 01/30/14 at 3:15 p.m. with the Maintenance Supervisor, a fire drill report for the second and third shift of</p>	K010050	<p>Corrective Action A Monthly Fire Drill Report will be completed quarterly for each shift. The drills for the thrid quarter are as follows: October 30, 2013 at 4pm, November 24, 2013 at 10pm and December 31,2013 at 1:57pm. Drills have been conducted for January 2014 and all three shifts for February 2014.. Identification Residents have the potential to be affected by this alleged deficient practice. System Change Conduct monthly fire drills on all 3 shifts per quarter at unexpected</p>	01/30/2014	

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K010051 SS=F	<p>the third quarter of 2013 was not available for review. Based on interview on 01/30/14 at 3:17 p.m. with the Maintenance Supervisor, it was acknowledged the fire drills for the aforementioned shifts of the third quarter of 2013 had not been done.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999</p>	K010051	<p>times. MonitoringThe administrator/designee will review/participate in 3 monthly fire drills that are conducted on all three shifts for 3 months and monthly for 9 months.. Any identified issues/concerns/problems will be reported to the QA committee for further discussion/review and recommendations.</p> <p>Corrective ActionThe fire alarm system circuit breaker has been marked in red and labeled as FIRE ALARM CIRCUIT CONTROL. IdentificationResident</p>	02/28/2014			

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K010052 SS=E	<p>Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/30/14 at 1:56 p.m. with the Maintenance Supervisor, the fire alarm system circuit breaker located in the Mechanical room on Service hall lacked full identification. The circuit breaker was marked "facp" in black. Based on interview on 01/30/14 at 1:57 p.m. with the Maintenance Supervisor, it was acknowledged the circuit breaker was not labeled with red marking to say Fire Alarm Circuit Control.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p>		<p>s have the potential to be affected by this alleged deficient practice. System ChangeThe circuit breaker system now has the color red on the breaker switches and next to the switches is a label which reads "FIRE ALARM CIRCUIT CONTROL" and it is also labeled on the door and described as the fire alarm circuit panel. MonitoringThe Maintenance supervisor/designee will check the circuit breaker monthly for one year to assure the breakers are red and they are labeled as "FIRE ALARM CIRCUIT CONTROL".</p>				

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	<p>Based on observation and interview, the facility failed to ensure 1 of 12 manual fire alarm boxes were unobstructed and readily accessible. NFPA 72, National Fire Alarm Code, 2-8.2.1 states manual fire alarm boxes shall be distributed throughout the protected area so they are unobstructed, readily accessible, and located in the path of exit from the area. This deficient practice could affect 4 residents observed in the lounge area as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/30/14 at 12:15 p.m. with the Maintenance Supervisor, the manual fire alarm box provided for the Front entrance was located in the exit foyer of the Front entrance which was only accessible by the use of a keypad override code which would disengage the magnetically locked doors thus delaying alarm notification to facility occupants. Based on interview on 01/30/14 at 12:20 p.m. with the Maintenance Supervisor, it was acknowledged the manual fire alarm box was not accessible once inside the facility unless the keypad override code was used to first disengage the magnetically locked doors.</p> <p>3.1-19(b)</p>	K010052	<p>Corrective ActionThe manual fire alarm box has been moved to an accessible area at the Front entrance. IdentificationResidents have the potential to be affected by this alleged deficient practice. System ChangeThe manual fire alarm box was removed from the wall next to the second set of exit doors. The manual fire alarm box was reinstalled in the area of the first set of exit doors which contains the locking mechanism. MonitoringMaintenance Supervisor will audit manual pull stations monthly to assure they are positioned correctly.</p>	02/17/2014			

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, Section 5-1.1 states sprinklers shall be installed throughout the premises. This deficient practice could affect 8 residents on 300 south hall as well as staff and visitors adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 01/30/14 at 1:20 p.m. with the Maintenance</p>	K010056	<p>Correctivre ActionThere is a functioning sprinkler head in the walk in cooler located in the back left hand corner of the cooler. A picture of the sprinkler head is being mailed with the signature page of the 2567. . This sprinkler head has been in the cooler since the cooler installation approximately 40 years ago. Identification.If there was not a sprinkler head, residents would have the potential to be affected by this practice. System ChangeThe sprinkler has existed since the installation of the cooler approximately 40 years ago. MonitoringThe Maintenance Supervisor will audit the cooler sprinkler head monthly.</p>	01/30/2014
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K010062 SS=F	<p>Supervisor, the walk-in cooler located in the kitchen lacked sprinkler protection. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the lack of sprinkler protection in the walk-in cooler.</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 observation and interview, the facility failed to provide a complete supply of spare sprinklers in 1 of 1 riser rooms. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents throughout the facility as well</p>	K010062	<p>Corrective Action1. Two new sprinkler heads with green glass filaments have been stored in cabinet in riser room.2. The fire hydrant that is located outside in back property close to the property line was inspected and tested by an outside contractor. IdentificationResidents have the potential to be affected by this alleged deficient practice. System Change1. Two new sprinkler heads with green glass filament were purchased and stored in cabinet.2.An outside company was hired to inspect and test the outside fire hydrant.MonitoringThe Maintenance Supervisor/designee will check stored sprinkler heads monthly to assure each type of sprinkler head has 2 replacements in</p>	02/28/2014

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	<p>as staff and visitors if the sprinkler system had to be shut down because a proper sprinkler head wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation on 01/30/14 at 1:55 p.m. with the Maintenance Supervisor, the riser room on 100 south hall had two identical pendant type sprinkler heads with green filaments being utilized, however, there were no pendant type sprinkler heads with a green glass filaments in the spare sprinkler cabinet located in the Riser room on 100 south hall. Based on interview on 01/30/14 at 1:56 p.m. with the Maintenance Supervisor, it was acknowledged the spare sprinkler cabinet located in the Riser room did not have a minimum of two pendant sprinkler heads with green glass filaments in the sprinkler box.</p> <p>3.1-19(b)</p> <p>2. Based on observation, record review and interview, the facility failed to ensure 1 of 1 private fire hydrants was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection,</p>		<p>stock. The Maintenance Supervisor/designee will audit annually the testing of the fire hydrant by an outside company.</p>	

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	<p>Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all residents in the facility as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/30/14 at 2:20 p.m. with the Maintenance Supervisor, there was one fire hydrant located on the southeast exit portion of the facilities property. Based on review of Fire Systems report on 01/30/14 at 3:21 p.m. with the Maintenance Supervisor, the facility lacked documentation of an annual inspection for the private fire hydrant. Based on interview concurrent with record review with the Maintenance Supervisor, it was confirmed the fire hydrant was on the property, considered to be private and documentation of an annual fire hydrant inspection was not available for review. The facility was unaware the fire hydrant needed to be serviced annually.</p> <p>3.1-19(b)</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
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>1. Based on observations and interview, the facility failed to ensure 1 of 22 portable fire extinguishers were installed correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect 8 residents observed in the Main Dining room including staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 01/30/14 at 2:05 p.m. with the Maintenance Supervisor, the fire extinguisher observed on the north wall of the Main Dining room was measured to be installed with the top of the fire extinguishers at sixty seven inches from the floor. Based on interview on 01/30/14 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned portable fire</p>	K010064	<p>Corrective ActionThe fire extinguisher that was in the therapy room was within the normal range as evidenced by the at picture that will be mailed with the signature page of the 2567.. The needle on the gauge was right on the line of being normal. A replacement fire extinguisher has been placed in the therapy room.The fire extinguisher that was located in the dining room has been replaced with a shorter extinguisher to assure a height of no more than 60 inches. IdentificationResident have the potential to be affected by this alleged deficient practice. System changesThe fire extinguisher in the therapy room and the the extinguisher in the dining room have been replaced. MonitoringThe Maintenance supervisor/designee will inspect the fire extinguishers monthly for one year to assure proper fillage and proper height of mounted extinguisher.</p>	02/28/2014			

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K010130 SS=F	<p>extinguisher was over sixty inches from the floor.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 2 boiler vessels in the Mechanical room in room B 2738 was installed correctly. NFPA 101 at 19.1.1.3 states all health care facilities shall be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 8 residents on 300 south hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on review of the Boiler Vessel Pressure Inspection report on 01/30/14 at 3:35 p.m. with the Maintenance</p>	K010130	<p>Corrective Action1. The boiler pressure vessel will be replumbed to assure that the inlet of the boiler will have water flowing in and the outlet will have the water flowing out. A pressure gauge has been installed.2.All smoke detectors were inspected in February 2014 and will be inspected by maintenance monthly thereafter. IdentificationResidents have the potential to be affected by this alleged deficient practice. System ChangeAll boiler vessels have been inspected by outside inspector to assure all were plumbed correctly and pressure gauges are present. The battery operated smoke detectors have been put on a monthly inspection schedule. MonitoringThe</p>	02/28/2014			

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	<p>Supervisor, the inspection report dated 12/20/13 indicated the installation of the new boiler vessel pressure tank inside room B 2738 lacked a pressure gauge and was plumbed backwards in that the direction of water flow was first run into the outlet and the outflow was plumbed into the inlet of the boiler vessel pressure tank. Based on interview at the time of record review, the Maintenance Supervisor it was acknowledged the boiler vessel pressure tank had not yet complied with the inspection report and was still in use without a pressure gauge.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 49 of 49 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect 58 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review on 01/30/14 at 3:10 p.m. with the Maintenance Supervisor, the Preventative</p>		<p>maintenance supervisor/designee will inspect battery operated smoke detectors monthly to assure batteries are in working order. Annually an outside inspector will inspect all boiler vessels to assure proper plumbing of those vessels and that pressure gauges are present.</p>				

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K010143 SS=E	<p>Maintenance Book did not have documentation indicating a battery replacement program or monthly inspections of the forty nine single station smoke detectors in the resident rooms. Based on an interview with the Maintenance Supervisor on 01/30/14 at 3:11 p.m., there is no documentation for the replacement of single station smoke detector batteries or monthly maintenance checks.</p> <p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the</p>	K010143	Corrective ActionThe oxygen storage room has been provided	02/25/2014

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	<p>facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transfer occurs had continuously working, electrically powered mechanical ventilation. This deficient practice could affect 21 residents on 100 south hall as well as visitors and staff in the area.</p> <p>Findings include:</p> <p>Based on observation on 01/30/14 at 1:46 p.m. with the Maintenance Supervisor, the oxygen storage room on 100 south hall used to store and transfer oxygen was provided with electrically powered mechanical ventilation, but it was not working. Based on interview on 01/30/14 at 1:50 p.m. it was acknowledged by the the Maintenance Supervisor this room was used to transfer oxygen and though it had an electrically powered mechanical vent, it was not working at the time of inspection.</p> <p>3.1-19(b)</p>		<p>with working electrically powered mechanical ventilation. Identification Residents have the potential to be affected by this alleged deficient practice. System Changes An electrical powered ventilation fan was installed in the oxygen storage room. Monitoring Maintenance Supervisor/designee will inspect ventilation fan monthly for one year to assure working order.</p>		

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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This</p>	K010144	<p>Corrective Action1. A monthly load test was performed on the emergency generator and documented.2. A letter has been requested from NIPSCO that contains a statement of reasonable reliability of the natural gas delivery, a brief description that supports the statement regarding the reliability, a statement that there is a low probability of interruption of the natural gas, a brief description that supports the statement regarding the low probability of interruption and the signature of a technical person from NIPSCO. IdentificationResidents have the potential to be affected by the alleged deficient practice. System ChangesAn amp tester/volt meter was purchased and used when emergency generator tested. The percentage of load was documented. This will be done on a monthly basis.Have requested letter from NIPSCO regarding a reliable off-site fule source for the emergency generator. MonitoringThe administrator/designee will review load test results monthly for one year.Administrator will assure that letter from NIPSCO is received and kept with Life Safety Manual.</p>	02/28/2014			

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	<p>deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Generator System Testing records and Maintenance logs on 1/30/14 at 3:38 p.m. with the Maintenance Supervisor, the amperage during load was documented but the percentage of the load was not calculated to verify it ran at 30 percent, or more, of the EPS nameplate rating for the past twelve months. Based on interview on 01/30/14 concurrent with record review with the Maintenance Supervisor, it was acknowledged the facility had been running the generator and recording the amperage, but was unaware how to calculate load or even if the procedure used was correct for doing a monthly load test. No other equivalent method was used to comply with percentage of load capacity for the past twelve months.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure the off-site fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and</p>				

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	<p>Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <ul style="list-style-type: none"> <li>a) Liquid Petroleum products at atmospheric pressure</li> <li>b) Liquefied petroleum gas (liquid or vapor withdrawal)</li> <li>c) Natural or synthetic gas</li> </ul> <p>Exception: For Level 1 installations in locations where the probability of interruption of offsite fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:</p> <ul style="list-style-type: none"> <li>1. A statement of reasonable reliability of the natural gas delivery.</li> <li>2. A brief description that supports the statement regarding the reliability.</li> <li>3. A statement that there is a low probability of interruption of the natural</li> </ul>						

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K010147 SS=E	<p>gas.</p> <p>4. A brief description that supports the statement regarding the low probability of interruption;</p> <p>5. The signature of technical personnel from the natural gas vendor. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review of the Generator Maintenance Log on 01/30/14 at 3:16 p.m. with the Maintenance Supervisor, there was no letter from a natural gas vendor to indicate it was from a reliable source. Based on interview on 01/30/14 at 3:17 p.m. with the Maintenance Supervisor, it was acknowledged the facility does not have a letter of statement from their natural gas provider indicating the natural gas was from a reliable source.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 extension</p>	K010147	Corrective Action The extension cord in the MDS office has been removed and the second power	02/28/2014			

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	<p>cords was not used as a substitute for fixed wiring. 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 could affect 8 residents on 300 south hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/30/14 at 2:11 p.m., with the Maintenance Supervisor, an extension cord used in the MDS office on 300 south hall was connected to one power strip to power a second power strip which then provided power for a printer, computer and a mini refrigerator. Based on interview on 01/30/14 at 12:12 p.m. it was acknowledged by the Maintenance Supervisor, an extension cord was used to provide power to the aforementioned appliances via two power strips and it was mentioned extension cords were not allowed in the facility.</p> <p>3.1-19(b)</p>		<p>strip was removed from the first power strip.</p> <p>IdentificationResidents may have the potential to be affected by this alleged deficient practice. System ChangesAll offices were inspected to assure there was no use of extension cords. MonitoringAdministrator/de signee will audit offices one time a month for one year to assure that extension cords are not it use.</p>		

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K010154 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to protect 58 of 58 residents by providing a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for more than 4 hours in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to</p>	K010154	<p>Corrective ActionThe written policy and procedure has been revised to include notification of impaired sprinkler system of more than 4 hours to the insurance carrier, owner and the Indiana State Dept. of Health. The written policy also addresses notifying all entities when the sprinkler system is restored. IdentificationResidents have the potential to be affected by this alleged deficient practice. System changesThe written policy and procedure has been revised to include notification of impaired sprinkler system of more than 4 hours to the insurance carrier, owner and the Indiana State Dept. of Health. The written policy also addresses notifying all entities when the sprinkler system is restored. MonitoringAdministrator will review/revise policies as needed.</p>	02/28/2014			

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	<p>those already mentioned and lastly 11-7 requires notification of everyone again when the system is restored. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on sprinkler record review on 01/30/14 at 3:25 p.m. with the Maintenance Supervisor, the facility did have a written policy and procedure for an impaired sprinkler system available for review, but it did not address notifying the Insurance Carrier, Owner/Operator and Indiana State Department of Health and then notify all six entities again once the sprinkler system has been restored to normal.</p> <p>Based on interview on 01/30/14 at 3:26 p.m. with the Maintenance Supervisor, it was acknowledged the fire watch policy did not include notifying the aforementioned entities and once again when the sprinkler system had been restored to normal operation.</p> <p>3.1-19(b)</p>				

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K010155 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written fire watch policy in the event the fire alarm system is out of service for more than 4 hours in a 24 hour period for the protection of 58 of 58 residents. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all residents, staff and visitors.</p>	K010155	<p>Corrective ActionThe written policy and procedure has been revised to include the notification of the Indiana Dept. of Health when fire protection system is impaired for 4 hours with in a 24 hour period. IdentificationResidents have the potential to be affected by this alleged deficient practice. System ChangeThe written policy and procedure has been revised to include the notification of the Indiana Dept. of Health when fire protection system is impaired for 4 hours within a 24 hour period. MonitorAdministrator will review/revise policies when necessary.</p>	02/28/2014			

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	<p>Findings include:</p> <p>Based on fire alarm record review on 01/30/14 at 3:37 p.m. with the Maintenance Supervisor, the facility did have a written policy and procedure for an impaired fire protection system available for review, but it did not address notifying the Indiana State Department of Health. Based on interview on 01/30/14 at 3:38 p.m. with the Maintenance Supervisor, it was acknowledged the fire watch policy did not include notifying the Indiana State Department of Health.</p> <p>3.1-19(b)</p>				