

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155203	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2013
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NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130
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K0000	<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: 02/05/13 and 02/06/13</p> <p>Facility Number: 000110 Provider Number: 155203 AIM Number: 100271120</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hillcrest Village 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>Hillcrest Village is a two story building with a finished partial basement. The building was constructed at two different times. The original building was built in 1966 and constructed with mixed construction consisting of a two and one half inch thick concrete decks separating</p>	K0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for survey ending 2/6/13. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance.</p>	

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>each floor, one hour fire rated smoke barrier walls, two fire barrier walls constructed of two hour construction on each level, brick exterior walls with metal studs and one half hour rated drywall, a mix of concrete and metal stud interior walls with one half hour rated drywall, and metal trusses and wooden rafters in the roof assembly. Based on the lowest construction type, the facility construction type was classified as Type V (111) construction. The original building was built with an open column foundation exposed at the entire south length of the facility. In 1974, a two story addition including the level 1 Transcare Unit and level 2 East Wing was constructed to the southeast of the original building and the column foundation was converted into a poured finished partial basement for physical therapy and is also of Type V (111) construction. Because the original building and the addition are the same type of construction, the facility was surveyed as one building.</p> <p>The facility is fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 180 and had a census of 92 at the time of this survey.</p>				

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	<p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except the detached laundry building and the detached storage shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/12/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0021 SS=E	<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> <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 1 of 1 kitchen service metal rolling doors was held open only by a device arranged to automatically close upon activation of the fire alarm system. This deficient practice could affect 65 residents who use the main dining room as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 02/06/13 at 12:00 p.m. during a tour of the facility with the maintenance supervisor, the metal rolling service door between the kitchen and dining room was held open with a chain and fusible link which would not allow the door to close automatically when the fire alarm system is actuated. Furthermore, on 02/06/13 at 12:10 p.m.</p>	K0021	<p>K021What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice:The metal rolling door will be repaired or replaced with automatic roll down door and will be connected to the fire alarm system on or before March 8, 2013. How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice.Maintenance and Dietary staff will be in-serviced on the automatic roll down function by the SDC.What measures will be put into place or what systemic changes you will make to ensure the</p>	03/08/2013			

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	<p>with the maintenance supervisor, the fire alarm system was activated and the kitchen metal rolling service door failed to close when the fire alarm system was activated. This was verified by the maintenance supervisor at the time of observation and confirmed by the director of nursing at the exit conference on 02/06/13 at 12:30 p.m.</p> <p>3.1-19(b)</p>		<p>deficient practice does not recur: The automatic roll down door will be placed on a preventative maintenance monthly schedule. The maintenance director will conduct the inspection monthly. The maintenance director will report findings to the ED. If non-compliant areas are identified an action plan will be developed. The annual inspection will be conducted by the 360 services annually. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The maintenance director will complete the Environmental Safety CQI Audit Tool weekly x 4 weeks and monthly x 6 months. The CQI Committee will determine the need for further review.</p>		

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K0025 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>Based on observations and interview, the facility failed to ensure 2 of 8 attic smoke barriers were constructed to provide at least a one half hour fire resistance rating. This deficient practice affects 14 residents who reside on the 1 West Hall, and 14 residents who reside on the 1 East Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 02/06/13 during observations of the attic smoke barriers above the smoke barrier doors from 11:45 a.m. to 12:30 p.m., the following attic smoke barrier walls above smoke barrier doors had penetrations with no fire stopping material:</p> <p>a. The 1 West Hall smoke barrier wall had three, two inch diameter areas around electrical conduit penetrations with no fire stopping material.</p> <p>b. The 1 East Hall smoke barrier wall had</p>	K0025	<p>K 025 What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice: All areas identified as a concern were repaired with appropriate fire rated caulking/drywall including: a. The three 2 inch diameter of the 1 West Hall smoke barrier wall. b. The five 1/2 inch diameter of the 1 East Hall smoke barrier wall. How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this practice. Maintenance Director will be in-serviced on the requirements of K025. The smoke barrier walls were inspected in the attic to ensure no other penetrations were identified. What measures will be put into place or what systemic</p>	03/08/2013
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	<p>five, one half inch diameter areas around electrical conduit penetrations with no fire stopping material.</p> <p>The West Hall and 1 East Hall smoke barrier penetrations without firestopping was verified by the maintenance supervisor at the time of observations and confirmed by the Director of Nursing at the exit conference on 02/06/13 at 12:30 p.m.</p> <p>3.1-19(b)</p>		<p>changes you will make to ensure the deficient practice does not recur: The Maintenance Director will be responsible for ensuring that work completed by vendors, contractors and etc. are thoroughly inspected after completion of work to ensure no penetrations occur. The Maintenance Director will conduct random audits of smoke barrier walls through the preventative maintenance program and document findings in the preventative maintenance book. If non-compliant areas are identified the ED will be notified and action plan developed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The maintenance supervisor will complete the Environmental Safety CQI Audit Tool weekly x 4 weeks and monthly x 6 months. The CQI Committee will determine the need for further review.</p>		

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K0027 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 Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes and 1 of 7 sets of smoke barrier doors were provided with a fire resistance rating. LSC, Section 19.3.7.6 requires doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 32 residents who reside on the 2 South Hall and 18 residents who reside on the 2 East Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 02/06/13 at 9:20 a.m., the 2 South Hall set of smoke</p>	K0027	<p>K 027 What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice: The 2 South Smoke Barrier door will be repaired and now functions according to K027.Paint was removed from the fire resistant label of The 2 East Hall Smoke barrier doors.How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this practice.The Maintenance Director was inserviced on the requirements of K027.What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: The facility Fire Drill report will be revised to include inspection of the fire doors. The monthly fire drill report will</p>	03/08/2013	

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	<p>barrier doors did not close completely, leaving a two inch gap where the doors came together. Furthermore, based on observation on 02/06/13 at 10:05 a.m. with the maintenance supervisor, the 2 East Hall set of smoke barrier doors' fire resistance label was covered with white paint. The 2 South Hall smoke barrier door gap and 2 East Hall smoke barrier doors' fire resistance label being covered with paint was verified by the maintenance supervisor at the time of observation and confirmed by the Director of Nursing at the exit conference on 02/06/13 at 12:30 p.m.</p> <p>3.1-19(b)</p>		<p>be reviewed by the Administrator monthly to ensure completion. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Maintenance Director and/or designee will complete the Environmental Safety CQI Audit Tool report findings to the CQI committee weekly x 4 weeks and monthly x 6 months.</p>		

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K0033 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 stairway exit doors was provided with a label indicating the fire resistance rating of the stairway door. LSC 8.2.5.4 refers to 7.1.3.2.1 for enclosure of exits. LSC 7.1.3.2.1(a) says the separation shall have not less than a 1 hour fire resistance rating where the exit connects three stories or less. This deficient practice could affect 22 residents who reside on the 2 South Hall.</p> <p>Findings include:</p> <p>Based on observation on 02/06/13 at 11:10 a.m. with the maintenance supervisor, the 2 South Hall stairway exit door's fire resistance rating label was covered in white paint so the fire resistance rating of the door could not be verified. This was acknowledged by the maintenance supervisor at the time of observation and confirmed by the Director of Nursing at the exit conference on 02/06/13 at 12:30 p.m.</p>	K0033	<p>K033What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice: The paint was removed from the fire resistance rating label of the 2 South Hall stairway exit door.How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action will be taken: All Residents have the potential to be affected by this alleged deficient practice.The Maintenance Director was in-serviced on the requirements of K033.The Maintenance Director inspected all exit doors to ensure all fire resistance labels are intact and legible. What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: The preventative maintenance log will be revised to include ensuring the fire resistance label are legible through observation.The Maintenance</p>	02/08/2013			

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	3.1-19(b)		Director will complete the log monthly ongoing. The maintenance supervisor will report findings to the ED. If non - complaint areas are identified a action plan will be developed.How the corrective action(s) will be monitored to ensure the deficient practice will not recur:The Maintenance Director will complete the Environmental Safety CQI Audit Tool weekly x 4 weeks and monthly x 6 months. Findings will be reported to the CQI committee for further review		

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K0038 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>1. Based on observation and interview, the facility failed to ensure 1 of 6 exit accesses with stairs was provided with handrail. LSC 7.2.2.4.2 requires stairs and ramps shall have handrails on both sides. In addition, handrails shall be provided within 30 inches of all portions of the required egress width of stairs. The required egress width shall be provided along the natural path. Exception No 3: Existing stairs, existing ramps, stairs within dwelling units and within guest rooms, and ramps within dwelling units and guest rooms shall be permitted to have a handrail on one side only. This deficient practice could affect 28 residents who reside on the 2 W Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 02/06/13 at 11:45 a.m., the 2 E Hall exit discharged on to a fourteen foot long sidewalk leading to the west parking lot. The sidewalk had two steps where the sidewalk met the parking lot with no handrail along the outside of the steps. This was verified by the maintenance supervisor at the time of observation and</p>	K0038	<p>K 038 What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice: The 2 East Sidewalk will be repaired and have handrails installed on or before March 8, 2013 by an outside contractor. The elevation changes to the 2 East steps/sidewalk will be corrected on or before March 8, 2013 by the regional maintenance staff. How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this alleged deficient practice. All exits were inspected by the Maintenance Director to ensure all sidewalks are even without elevation and stairs have rails. No other areas were identified. The Maintenance Director will be responsible for checking the sidewalk and handrails monthly to ensure compliance with K038. What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: The Preventative Maintenance Monthly Checklist will be revised to include a monthly task checking sidewalks</p>	03/08/2013			

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	<p>confirmed by the Director of Nursing at the exit conference on 02/06/13 at 12:30 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the sidewalk surface on 1 of 6 exit sidewalks was maintained to prevent elevation changes. LSC 7.1.6.2 requires abrupt changes in elevation of the walking surface shall not exceed 1/4 inch. Changes in elevation exceeding 1/4 inch, but not exceeding 1/2 inch shall be beveled 1 to 2. Changes in elevation exceeding 1/2 inch shall be considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice could affect 28 residents who reside on the 2 W Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 02/06/13 at 11:45 a.m., the 2 W Hall exit had a twelve foot by fourteen foot concrete slab outside the exit door. Furthermore, the 2 W Hall exit concrete slab outside the exit door had a one inch elevation change where it met the adjoining north and south sidewalks leading to the parking lot. This was verified by the maintenance supervisor at the time of observation and</p>		<p>and handrails to ensure areas are even without elevations and handrails are intact. The Maintenance Director will complete the Preventative Maintenance Checklist monthly and report findings to the ED. If non compliance is identified an action plan will be developed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Maintenance Director and/or designee will complete the Environmental Safety CQI Audit Tool weekly x 4 weeks and monthly x 6 months. The CQI committee will determine need for further review.</p>				

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	confirmed by the Director of Nursing at the exit conference on 02/06/13 at 12:30 p.m. 3.1-19(b)			

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K0046 SS=A	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation, record review and interview; the facility failed to ensure 1 of 1 battery backup lights was tested annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice does not affect any residents, but affects maintenance and laundry staff who use the detached laundry building.</p> <p>Findings include:</p> <p>Based on record review on 02/05/13 at 9:45 a.m. with the maintenance supervisor, the Emergency Lighting Log</p>	K0046	<p>K0046What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice: An annual test was conducted on the battery powered emergency lighting for 1 1/2 hours on 2/18/13, The testing was documented on the Battery Operated Emergency Lights-Test Log 2013.How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action will be taken: The Maintenance Director was in-serviced on the appropriate testing of battery back up lighting in accordance with K0046 7.9 19.2.9.1.The Executive Director or designee will review the Preventative Maintenance Logs monthly to ensure testing is completed timely.What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: The Preventative Maintenance Annual Task Log will be revised to specify the 1 1/2 hour testing of Battery-Operated Emergency Lights.The Maintenance Director/designee will be responsible for completing the annual testing of battery operated emergency lights.The Executive</p>	03/08/2013			

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	<p>was reviewed and indicated a monthly test of the battery backup light in the detached laundry building but lacked an annual ninety minute test. This was verified by the maintenance supervisor at the time of observation and confirmed by the Director of Nursing at the exit conference on 02/06/13 at 12:30 p.m.</p> <p>3.1-19(b)</p>		<p>Director will review the Preventative Maintenance Book monthly to ensure completion. If non compliance areas are identified a action plan will be developed.How the corrective action(s) will be monitored to ensure the deficient practice will not recur:The maintenance director will complete the Environmental Safety CQI Audit Tool x 4weeks and monthly x 6 months. The CQI committee will determine need for further review.</p>		

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K0062 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 17 of over 300 sprinklers covered in white paint in the facility. 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 65 residents who reside on the second floor of the facility.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility on 02/06/13 from 9:00 a.m. to 12:20 p.m. with the maintenance supervisor, the following locations had sprinklers covered with white paint: one sprinkler in the speech office, six sprinklers in the main dining room, one sprinkler in the kitchen, one sprinkler in the kitchen storage room, one sprinkler in the main dining room restroom, one</p>	K0062	<p>K062 What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice: All cited sprinkler heads with paint will be removed and replced with new heads by March 8, 2013.How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action will be taken: All resident have the potential to be affected by this deficient practice.All sprinkler heads will be inspected by March 8, 2013 to ensure sprinkler heads are free of paint/debris. Any negative findings will be corrected by the outside contractor.The Maintenance Director will be in-serviced on the requirements of K062.What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: The Preventative Maintenance Monthly Task Checklist will be revised to include inspection of sprinkler heads monthly. The Maintenance Supervisor/designee will complete the inspection monthly and report findings to the ED. If non-compliance areas are</p>	03/08/2013
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	<p>sprinkler in the bathroom of resident room 306, one sprinkler in the closet of resident room 305, three sprinklers in the 2E Hall dining room, one sprinkler in the 2E Hall soiled linen room, one sprinkler in the 2S Hall stairway. The sprinklers covered with white paint were verified by the maintenance supervisor at the time of observations and confirmed by the Director of Nursing at the exit conference on 02/06/13 at 12:30 p.m.</p> <p>3.1-19(b)</p>		<p>identified a action plan will be developed. The Maintenance Director will be responsible for ensuring that work completed by vendors, contractors and etc. are thoroughly inspected after completion of work to ensure sprinkler heads are free of paint and debris.How the corrective action(s) will be monitored to ensure the deficient practice will not recur:The Maintenance Supervisor/designee will complete the Environmental Safety CQI Audit Tool weekly x 4 weeks and monthly x 6 months. The CQI Committee will determine need for further review.</p>				

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K0066 SS=E	<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. 19.7.4</p> <p>Based on observation, record review, and interview; the facility failed to ensure the metal self closing containers for discarded smoking materials were used in 2 of 3 areas where smoking was permitted. This deficient practice could affect 86 residents who reside on the 2 E Hall and 2 W Hall if a fire occurred outside in the second floor courtyard and second floor Administration Hall smoking locations.</p> <p>Findings include: Based on observation on 02/06/13 during</p>	K0066	K0066What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice: The metal trash container and plastic garbage cans were immediately removed from the second floor courtyard and the Administration hall (designated smoking areas).How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action will be taken: Staff and residents were re-educated on proper disposal of trash in both of the smoking	03/08/2013			

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	<p>a tour of the second floor courtyard and second floor Administration Hall smoking locations with the maintenance supervisor from 10:50 a.m. to 11:20 a.m., both smoking locations had a metal container with a self closing cover, however, plastic garbage cans were used to discard smoking material. Furthermore, each area had a plastic garbage can with approximately one hundred unlit cigarette butts mixed in with paper and plastic. This was verified by the maintenance supervisor at the time of observations and confirmed by the Director of Nursing at the exit conference on 02/06/13 at 12:30 p.m.</p> <p>3.1-19(b)</p>		<p>areas. The Maintenance Director or designee will be responsible for cleaning up the designating smoking areas daily. What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: The Maintenance Director or Designee will be responsible for cleaning up the designating smoking areas daily. The Environmental Supervisor and/or designee will ensure the designated smoking areas are cleaned daily. Non compliance will be reported to the Executive Director upon occurrence and further education and corrective action will be implemented. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The maintenance director will complete the Environmental Safety CQI Tool weekly x 4 weeks and monthly x 6 months. The CQI Committee will determine need for further review.</p>		

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K0067 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation, record review and interview; the facility failed to ensure 33 of 33 fire dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on observations on 02/05/13 during a tour of the facility from 9:30 a.m. to 1:20 p.m. and 02/06/13 during a tour of the facility from 9:00 a.m. to 12:20 p.m. with the maintenance supervisor, the</p>	K0067	<p>K0067What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice: Swift Air Mechanical will be conducting the fire damper inspection on or before March 8, 2013. The inspection will include all 33 dampers.How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this alleged deficient practice.The Maintenance Director will be in-serviced on the requirements of K067. What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: The Maintenance Director will document the inspection and record in the preventative maintenance annual inspection log. The Administrator will pre schedule the inspection with Swift Air to ensure the inspection occurs every 4 years.How the corrective action(s) will be monitored to ensure the deficient practice will not recur:The Executive Director will report to the corporate director of physical</p>	03/08/2013
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	<p>kitchen had five fire dampers, the 2E Hall had seven fire dampers, the 2E Center Hall had five fire dampers, and the 2W Hall had sixteen fire dampers. Based on an interview with the maintenance supervisor on 02/05/13 during record review at 10:10 a.m., there was no evidence to indicate the thirty three fire dampers were inspected over the past four years. This was confirmed by the Director of Nursing at the exit conference on 02/06/13 at 12:30 p.m.</p> <p>3.1-19(b)</p>		<p>plant the schedule for the damper inspection to occur every 4 years on-going.</p>		

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K0147 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 4 of 42 first floor resident rooms did not use flexible cords as a substitute for fixed wiring to provide power for medical electrical devices. NFPA 70, National Electrical Code, 1999 Edition, 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 who reside rooms 314, 319, 413, and 148.</p> <p>Findings include:</p> <p>Based on observation during a tour of the first floor with the maintenance supervisor on 02/06/13 from 9:00 a.m. to 10:30 a.m., resident rooms 314, 319, 413, and 148 used power strip extension cords to power suction machines, electric beds, feeding tubes and oxygen concentrators. This was verified by the maintenance supervisor at the time of observations and confirmed by the Director of Nursing at the exit conference on 02/06/13 at 12:30 p.m.</p> <p>3.1-19(b)</p>	K0147	<p>K 147 What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice: Power strips were immediately removed from rooms 314, 319, 413, and 148. How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action will be taken: Housekeeping and Maintenance Staff will be in-serviced on the appropriate use of power strips and the requirements of K147. The Maintenance Director will conduct a room to room audit to ensure all medical devices are not plugged into power strips. If non compliance issues are identified further education will be conducted with the appropriate staff and family members if deemed necessary. What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: The preventative maintenance weekly task sheet will be revised to include random resident room audits of medical equipment. The Maintenance Director will report findings to the Executive Director. If non-compliant areas are identified a action plan will be developed. How the corrective</p>	03/08/2013	

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			action(s) will be monitored to ensure the deficient practice will not recur: The Maintenance Director will complete the Environmental Safety CQI Audit Tool weekly x 4 weeks and monthly x 6 months. The CQI committee will determine need for further review.	