

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/21/2014
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NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630
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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: 01/21/14</p> <p>Facility Number: 012966 Provider Number: 155803 AIM Number: 201110390</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hamilton Pointe Health and Rehab 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 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to</p>	K010000	<p>This Plan of Correction is prepared and executed because it is required by the Provisions of State and Federal regulations. The Village at Hamilton Pointe maintains that each deficiency does not jeopardize the health and safety of the residents, not is it of such a nature as to limit our capability to provide adequate care.</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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K010017 SS=F	<p>the corridors, and all resident sleeping rooms. The facility has a capacity of 115 and had a census of 77 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/28/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridor walls form a barrier to limit the transfer of smoke. Such walls are permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5 Based on observation and interview, the facility failed to ensure 9 of 9 open areas were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building or met an Exception. LSC 18-3.6.1, Exception # 1, Spaces shall be permitted to be unlimited in area and open to the corridor, provided that the</p>	K010017	<p>1. A electric automatic smoke detection system will be installed by February 19, 2014, by Safe Care, in the open areas located between rooms 308 and 310, next to 300 hall shower room, next to room 401, next to room 800, across from 900 hall lounge next to room 901, two across from 500 hall activity room and in Rehab area between 600 and</p>	02/20/2014	

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	<p>following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas, and (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers, and (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space, and (d) The space does not obstruct access to required exits. This deficient practice could affect all residents, as well as staff and visitors throughout the facility's resident room corridors.</p> <p>Findings include:</p> <p>Based on an observations on 01/21/14 between 1:00 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Supervisor, the facility had nine small open areas located throughout the facility's resident room corridors which were being used to store wheel chairs, a weight machine, and small</p>		<p>700 halls. 2. The facility was observed by the Maintenance Director on January 22, 2014, to have no areas with the exception of those listed in #1 to be without an electric smoke detection system in place per LSC Section 18-3.6.1. No concerns were noted. 3. The Maintenance Director will be reeducated by the Executive Director regarding LSC Section 18-3.6.1. This re-education will be completed by February 19, 2014. 4. Maintenance Director/Designee will observe the facility to ensure all areas are protected by an electrically supervised automatic smoke detection system and that they are in working order weekly for 6 weeks. The results of these observations will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>				

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K010018 SS=B	<p>paper shredders, plus some open areas were empty. Locations of open areas include: between rooms 308 and 310, next to 300 hall shower room, next to room 401, next to room 800, across from 900 hall Lounge, next to room 901, two across from 500 hall Activity room, and in Rehab area between 600 and 700 halls. There were no separating walls or doors to the corridors. Furthermore, Exception # 1, requirement (c) of the LSC Section 18-3.6.1 was not met because these open areas were not protected by an electrically supervised automatic smoke detection system. This was acknowledged by the Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 sets of double doors to the corridors were equipped with positive latches and latched into their door frames. This deficient practice could affect mostly staff in the service hall and any number</p>	K010018	<p>1. Automatic door latches will be installed by February 19, 2014, on the three sets of double doors to two Mechanical rooms in the service all and one Mechanical Room in the main corridor next to the DON office, plus one set of double doors to the paint storage</p>	02/20/2014

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	<p>of residents, as well as staff and visitors while in the main corridor between the main dining room and front entrance area.</p> <p>Findings include:</p> <p>Based on observations on 01/21/14 between 1:00 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Supervisor, three sets of double doors to two Mechanical Rooms in the service hall and one Mechanical Room in the main corridor next to the DON office, plus one set of double doors to the paint storage room in the service hall, would latch into each other, however, all four sets of double doors would not latch into their respective door frames automatically, they had to be manually latched with slide bolt latches located at the top and bottom of the doors. This was acknowledged by the Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b)</p>		<p>room in the service halls by the Maintenance Director. 2. All doors in the facility were observed by the Maintenance Director on January 22, 2014 to ensure all are equipped with automatic door latches that are required to be with the exception of the doors noted in #1. No concerns were noted. 3. The Maintenance Director will be reeducated by the Executive Director regarding LSC Section 18-3.6.3. This re-education will be completed by February 19, 2014.4. Maintenance Director/Designee will observe the facility to ensure all double doors areas have automatic door latches and that they are in working order weekly for six (6) weeks. The results of these observations will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</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. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8</p> <p>Based on observation and interview, the facility failed to ensure 1 of 8 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 18.3.7.6 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 9 residents in the 800 hall, plus any other residents, staff, and visitors in the crossing corridors of the 300, 400, and 900 halls.</p> <p>Findings include:</p> <p>Based on observation on 01/21/14 at 2:15 p.m. during a tour of the facility</p>	K010027	<p>1. The smoke barrier doors opening into the 800 hall will be repaired by February 19, 2014, by the Maintenance Director to ensure they close completely.</p> <p>2. All smoke barrier doors were observed by the Maintenance Director on January 22, 2014, with the exception of the doors listed in #1, to ensure all closed completely. No concerns were noted.</p> <p>3. The Maintenance Director will be reeducated by the Executive Director regarding LSC Section 8.3.4.1. This re-education will be completed by February 19, 2014.</p> <p>4. Maintenance Director/Designee will observe the all smoke barrier doors to ensure they close completely weekly for six (6) weeks. The results of these observations will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance</p>	02/20/2014			

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K010029 SS=B	<p>with the Maintenance Supervisor, the smoke barrier doors opening into the 800 hall did not close completely when tested. There was a half inch to one inch gap at the top portion of the doors when closed. This was acknowledged by the Maintenance Supervisor at the time of observation, furthermore, the Maintenance Supervisor said the doors appeared to be warped.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure 2 of 20 hazardous area room doors, such as boiler room doors, were equipped with self closing devices on the doors. This deficient practice could affect mostly staff and visitors while in the service hall.</p> <p>Findings include:</p> <p>Based on observation on 01/21/14 at 1:40 p.m. during a tour of the facility with Maintenance Supervisor, the</p>	K010029	<p>Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p> <p>1. Self-closing devices were installed on the double doors to the Mechanical Room across from the staff break by the Maintenance Director on January 27, 2014. 2. All doors in the facility were observed to have automatic door closers by the Maintenance Director on January 22, 2014, with the exception of the doors listed in #1. No concerns were noted. 3. The Maintenance Director will be reeducated by the Executive Director regarding LSC Section 7.2.1.8. This re-education will be completed by February 19, 2014.</p>	02/20/2014			

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K010046 SS=C	<p>Mechanical Room across from the Staff Breakroom had two gas fueled boilers. The set of double doors to this Mechanical Room were not provided with self closing devices. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1 Based on record review, interview and observation; the facility failed to ensure 1 of 1 battery powered light sets was tested monthly for 30 seconds and annually for 90 minutes. LSC 101, 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.</p>	K010046	<p>4. Maintenance Director/Designee will observe the facility to ensure all double doors areas have automatic door latches and that they are in working order weekly for six (6) weeks. The results of these observations will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p> <p>1. The identified light was verified by the Maintenance Director on January 22, 2014, not to be a battery backed up light fixture. 2. The Maintenance Director observed all outside lights to be backed up by the generator on January 22, 2104. No concerns noted. 3. The Maintenance Director will be reeducated by the Executive</p>	02/20/2014

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	<p>An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. NFPA 110, Section 5-3.1 requires Emergency Power Supply (EPS) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the generator log documentation and Disaster Emergency Plan book on 01/21/14 at 12:50 p.m. with the Maintenance Supervisor present, there was no documentation to show the battery back up light set outside the exit by the generator had been tested monthly for thirty seconds or a ninety minute annual test within the past twelve months. Based on interview at the time of record review, the Maintenance Supervisor acknowledged there was no documentation to show the battery back up light set at the generator exit was tested monthly for 30 seconds and annually for 90 minutes. Based on</p>		<p>Director regarding LSC Section 7.9.18.2.9.1. This re-education will be completed by February 19, 2014. 4. Maintenance Director/Designee will ensure all lights are backed up by the generator weekly for six (6) weeks. The results of these observations will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>	

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K010047 SS=E	<p>observation at 1:45 p.m. during a tour of the facility with the Maintenance Supervisor the battery back up light set was located too high above the exit door to test.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed with continuous illumination also served by the emergency lighting system in accordance with section 7.10. 18.2.10.1. Based on observation and interview, the facility failed to ensure a continuously illuminated exit sign, where the exit or way to reach the exit was not apparent, was provided over 2 of 8 sets of smoke barrier doors. LSC 18.2.10.1 refers to 7.10. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not apparent to the occupants. This deficient practice could affect 20 residents, as well as staff and visitors in the 600 and 700 halls.</p> <p>Findings include:</p> <p>Based on observations on 01/21/14 between 1:00 p.m. and 3:15 p.m. during</p>	K010047	<p>1. Exit signs that are served by the emergency lighting system will be installed over the two sets of smoke barrier doors within the 600 and 700 halls by February 19, 2014. 2. The Maintenance Director observed all areas where the exit or way to reach the exit was not apparent to have continuous illuminated exit signs served by the emergency lighting system on January 22, 2014, with the exception of the area identified in #1. No concerns noted. 3. The Maintenance Director will be reeducated by the Executive Director regarding LSC Section 7.10.1.4 and 18.2.10.1. This re-education will be completed by February 19, 2014. 4. Maintenance Director/Designee will ensure all exits contain a continuously illuminated signs also served by</p>	02/20/2014			

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K010050 SS=F	<p>a tour of the facility with the Maintenance Supervisor, there were no illuminated exit signs over the two sets of smoke barrier doors within the 600 and 700 halls. This was acknowledged by the Maintenance Supervisor at the time of each observation.</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. 18.7.1.2</p> <p>1. Based on record review and interview, the facility failed to ensure each documented fire drill included complete documentation of the transmission of a fire alarm signal to the monitoring company for 11 of 13 fire</p>	K010050	<p>the emergency lighting system weekly for six (6) weeks. The results of these observations will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p> <p>1. Drills occurred in the past and cannot be changed. 2. A fire drill will be held by the Maintenance Director by February 19, 2014 to ensure drills are being conducted at different times and on different shifts and that the monitoring company has</p>	02/20/2014			

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	<p>drills. LSC 18.7.1.2 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Disaster Emergency Plan book on 01/21/14 at 12:15 p.m. with the Maintenance Supervisor present, 11 of the 13 documented fire drill reports performed during the past twelve months did not include information the monitoring company received the transmission of the alarm. During an interview at the time of record review, the Maintenance Supervisor indicated the monitoring company was always contacted before and after a fire drill was conducted during all shifts, but acknowledged 11 of the 13 fire drill reports did not include this information.</p> <p>3-1.19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility.</p>		<p>received the transmission. 3. The Maintenance Director will be reeducated by the Executive Director regarding LSC Section 18.7.1.2. This re-education will be completed by February 19, 2014. 4. Maintenance Director/Designee will conduct fire drills at different times on different shifts and ensure/document that the monitoring company receives the transmission of the alarm monthly ongoing. The results of these observations will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>		

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K010052 SS=C	<p>Findings include:</p> <p>Based on review of the facility's fire drills in the Disaster Emergency Plan book on 01/21/13 at 12:15 p.m. with the Maintenance Supervisor present, three of four fire drills on the third shift (night) during the past twelve months were performed at 4:35 a.m., 4:45 a.m. and 4:45 a.m. During an interview at the time of record review, the Maintenance Supervisor acknowledged the times of the third shift fire drills were not varied.</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>Based on record review and interview, the facility failed to ensure the documentation for the annual testing of 186 of 186 smoke detectors, plus all pull stations and other devices connected to the fire alarm system was complete. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such</p>	K010052	<p>1. The annual fire alarm system inspection occurred in the past and cannot be corrected.</p> <p>2. A test of the fire alarm system will be held by February 19, 2014, by Safe Care to provide complete documentation of visual and functional testing of smoke detectors and all other devices connected to the fire alarm system.</p> <p>3. The Maintenance</p>	02/20/2014			

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K010062 SS=F	<p>as smoke detectors be tested annually. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's annual fire alarm system inspection testing report in the Disaster Emergency Plan book on 01/21/14 at 3:20 p.m. with the Maintenance Supervisor present, the annual fire alarm system inspection report dated 11/15/13 did not include complete information for visual and functional testing of smoke detectors and all other devices connected to the fire alarm system. During an interview at the time of record review, the Maintenance Supervisor acknowledged the fire alarm system inspection report dated 11/15/13 did not include complete information for visual and functional testing of all devices.</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. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review, observation and</p>	K010062	<p>Director will be reeducated by the Executive Director regarding LSC Section 9.6.1.4 and National Fire Alarm Code (NFPA) 72, 7-3.2. This re-education will be completed by February 19, 2014.</p> <p>4. Maintenance Director will ensure the annual fire alarm system inspection testing report includes information for visual and functional testing of smoke detectors and all other devices connected to the fire alarm system once per year. The annual report will be reviewed by the Quality Assurance Committee upon completion ongoing. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p> <p>1. The facility's fire hydrants will be inspected by February 19,</p>	02/20/2014			

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	<p>interview; the facility failed to ensure 5 of 5 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, 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 could affect all residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of the preventive maintenance records in the Disaster Emergency Plan book on 01/21/14 between 10:00 a.m. and 1:00 p.m. with the Maintenance Supervisor present, there was no documentation to show the facility's five fire hydrants have had an annual inspection. Based on interview at the time of record review, the Maintenance Supervisor said the facility's five fire hydrants have not been inspected during the past twelve months. Based on observation on 01/21/14 between 1:00 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Supervisor, there were five</p>		<p>2014 by Vanguard. 2. The facility's fire hydrants will be inspected by February 19, 2014, by Vanguard. 3. The Maintenance Director will be reeducated by the Executive Director regarding LSC Section 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5. This re-education will be completed by February 19, 2014. 4. Maintenance Director/Designee will ensure the facility's fire hydrants are inspected annually ongoing. The results of these inspections will be reviewed by the Quality Assurance Committee for a minimum of three (1) year and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>				

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K010069 SS=B	private fire hydrants on the facility's property. 3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily	K010069	1. The kitchen range hood was inspected on September 17, 2013 and the next inspection is scheduled for March 17, 2014. 2. The facility has one kitchen range hood and it was inspected on September 17, 2013 and the next inspection is scheduled for March 17, 2014. 3. The Maintenance Director will be reeducated by the Executive Director regarding LSC Section 9.2.3.18.3.2.6, NFPA 96. This re-education will be completed by February 19, 2014. 4. Maintenance Director/Designee will schedule kitchen range hood inspections twice a year and review the inspections twice a year for one (1) year to ensure compliance is met. The results of these inspections will be reviewed by the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as	02/20/2014
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	<p>sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect mostly kitchen staff.</p> <p>Findings include:</p> <p>Based on review of the kitchen range inspection reports in the Disaster Emergency Plan book on 01/21/14 at 11:55 a.m. with the Maintenance Supervisor present, there was no documentation to show the kitchen range hood had been inspected twice within the past twelve months. The only kitchen range hood inspection report was dated 09/17/13. This was acknowledged by the Maintenance Supervisor at the time of record review. Based on observation at 1:15 p.m. during a tour of the facility with the Maintenance Supervisor, there was only one date (09/17/13) on the sticker on the kitchen range hood to indicated the range hood had been inspected. This was confirmed by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.				

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K010144 SS=C	<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>Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include: Based on review of the facility's</p>	K010144	<ol style="list-style-type: none"> Vanguard will perform a load bank test showing the generator being exercised under operating conditions not less than 30 percent of the Emergency Power Supply for a minimum of 30 minutes by February 19, 2014. The facility has one generator. Vanguard will perform a load bank test showing the generator being exercised under operating conditions not less than 30 percent of the Emergency Power Supply for a minimum of 30 minutes by February 19, 2014. The Maintenance Director will be reeducated by the Executive Director regarding LSC 7.9.2.3 and NFPA 99, 3.4.4.1. This re-education will be completed by February 19, 2014. Maintenance Director/Designee will ensure the generator is tested under operating conditions of not less than 30 percent of the Emergency Power Supply nameplate rating for a minimum of 30 minutes monthly for three (3) months and ongoing. If thirty (30) percent load is not reached during a twelve (12) month period then Vanguard will do an annual load bank test. The results of these observations will be reviewed by the Quality Assurance Committee 	02/20/2014			

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	<p>Emergency Generator Load Test form on 01/21/14 at 12:05 p.m. with the Maintenance Supervisor present, the generator log form documented the generator was tested monthly under load, however, documentation showing the generator was exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes during the past twelve months was under the 30 percent requirement. The generator log form was provided with the question "Load" with the answer being 19 % each month. During an interview at the time of record review, the Maintenance Supervisor confirmed the monthly generator log showed the generator was exercised at only 19 %. Furthermore, during record review at 12:10 p.m. with the Maintenance Supervisor present, the most recent load bank test was dated 07/27/12. This was confirmed by the Maintenance Supervisor at the time of record review, furthermore, the Maintenance Supervisor said the generator was a diesel fueled generator.</p> <p>3.1-19(b)</p>		<p>for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>		