

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155211	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2015
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT LEBANON	STREET ADDRESS, CITY, STATE, ZIP CODE 1585 PERRY WORTH RD LEBANON, IN 46052
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K 0000  Bldg. 01	<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: 10/06/15</p> <p>Facility Number: 000118 Provider Number: 155211 AIM Number: 100290470</p> <p>At this Life Safety Code survey, Hickory Creek at Lebanon 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 V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and has battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 64 and had a census of 30 at the time of this survey.</p>	K 0000	<p>This plan of correction constitutes the written allegation of compliance for the deficiencies cited However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly This Plan of Correction is submitted to meet requirements established by state and federal law Hickory Creek at Lebanon desires this Plan of Correction to be considered the facility's Allegation of Compliance effective November 15, 2015</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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K 0025 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached buildings each housing an emergency generator, two detached storage buildings and one detached sprinkler system fire pump building which were each not sprinklered.</p> <p>Quality Review completed 10/08/15 - DA</p> <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 observation and interview, the facility failed to ensure openings through 1 of 13 smoke barrier walls were protected to maintain the fire resistance rating and smoke resistance of the smoke barrier wall. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is</p>	K 0025	<p><b>K 025 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> No residents were affected by this deficient practice. The smoke barrier wall in the attic has been repaired with fire rated material to provide at least one half hour fire resistance in accordance with 8.3 <b>How other</b></p>	10/21/2015

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	<p>capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the smoke barrier wall by Room 121.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 1:40 p.m. on 10/06/15, a five foot high by four foot wide hole was noted in the attic smoke barrier wall above the corridor door set by Room 121. Based on interview at the time of observation, the Maintenance Director acknowledged the opening in the aforementioned attic smoke barrier wall did not maintain the fire resistance rating of the smoke barrier wall and was not smoke resistant.</p> <p>3.1-19(b)</p>		<p><b>residents having the same potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</b> All residents living in this home have the potential to be affected by the same deficient practice. The smoke barrier wall in the attic has been repaired with material to provide at least one half hour fire resistance rating in accordance with 8.3. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> The smoke barrier wall in the attic has been repaired with material to provide at least one half hour fire resistance rating in accordance with 8.3. The monthly preventive maintenance schedule will be updated to include an inspection of the fire resistant barrier walls. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur ie, what quality assurance program will be put into place;</b> The monthly preventive maintenance schedule will be updated to include an inspection of the fire resistance walls and after contractors/vendors have been in the attic to ensure the barrier walls are intact. The results of the inspection of the fire resistant walls will be reported monthly in the safety meeting and monthly in the QAA meeting. <b>Compliance</b></p>		

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K 0038 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 3 of 7 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 1:40 p.m. on 10/06/15, the exit to door leading into the 300 Hall from the 200 Hall, the exit door</p>	K 0038	<p><b>Date; 10-21-2015</b></p> <p><b>K 038</b> <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> All residents identified by the surveyor now have the code by the key pad at the exit doors. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</b> All residents in this home have the potential to be affected by this deficient practice. The code to the exit doors is located by the key pad. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> The code to the exit doors is located by the key pad. The weekly preventive maintenance schedule will be updated with information to ensure the code to the exit doors remains by the key pad. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place;</b></p>	10/20/2015			

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K 0048 SS=C Bldg. 01	<p>by the 300 Hall Lounge and the exit door by Room 101 were each marked as a facility exit, the exit door was magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of observation, the Maintenance Director stated not all residents have a clinical diagnosis to be in a secure building and acknowledged the four digit code was not posted at the aforementioned three exits. Based on exit interview at 2:00 p.m., the Administrator confirmed not all residents have a clinical diagnosis to be in a secure building. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.</p> <p>3.1-19(b)</p> <p>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 1. Based on record review and interview, the facility failed to document a complete written health care occupancy fire safety plan for 1 of 1 plans which incorporated all items listed in NFPA 101, Section 19.7.2.2. (1) Use of alarms</p>	K 0048	<p>The weekly preventive maintenance schedule will be updated to ensure the exit door codes are by the key pads. The results of the weekly preventive maintenance schedule will be reported monthly at the safety meeting and reported at the monthly QAA meeting.</p> <p><b>Compliance Date:</b> 10-20-2015</p> <p><b>K 048 What corrective action(s) will be accomplished for residents found to have been affected by the deficient practice;</b> 1.No residents have been affected by the deficient practice. 2. No residents have been affected by the deficient practice.</p>	11/15/2015			

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	<p>(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 affects all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of "Disaster Manual: Evacuation Policy" documentation with the Maintenance Director during record review from 9:10 a.m. to 11:50 a.m. on 10/06/15, the written health care occupancy fire safety plan for the facility did not identify fire safety zones in the facility for the evacuation of smoke compartments. The aforementioned written fire safety plan stated "once the residents in the immediate effected area have been transferred to their first safety zone, all other residents in that corridor will be evacuated as quickly as possible" and "conduct a resident check to ensure that all residents from the corridor are present in the safety zone..." Based on interview at the time of record review, the Maintenance Director stated a fire</p>		<p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</b></p> <p>1. All residents in this home have the potential to be affected by this deficient practice. The Disaster Manual will be updated to address specifically the K class fire extinguisher.</p> <p>2. All residents in this home have the potential to be affected by this deficient practice. The Disaster manual will be updated to address specifically the K class fire extinguisher and it's appropriate usage.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>1. The Disaster Manual has been updated to include "Safe Zones". The staff will be in-serviced to the new Safe Zones and proper procedures to move residents from their home zone to a Safe Zone if there is a disaster.</p> <p>2. The Disaster Manual has been updated to address specifically the K class fire extinguisher, and when the K class fire extinguisher is to be used. The staff will be in-serviced specifically on the use of the K class fire extinguisher and when it is to be used.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</b></p>				

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	<p>safety zone within the facility is each adjacent smoke compartment behind a cross corridor smoke barrier door but acknowledged fire safety zones and the location of cross corridor smoke barrier doors are not identified in the written fire safety plan for the facility for evacuation purposes.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice could affect 3 staff in the kitchen.</p> <p>Findings include:</p>		<p><b><i>ie, what quality assurance program will be put intoplace;</i></b></p> <ol style="list-style-type: none"> <li>1. The in-service for the staff will be completed11-15-2015. The Disaster Manual will bepresented in the next monthly QAA meeting.</li> <li>2. The in-service for the staff will be Completed11-15-2015. The Disaster Manual will Bepresented in the next QAA meeting.</li> </ol> <p><b><i>Compliance Date:</i></b> 11-15-2015</p>				

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K 0062 SS=F Bldg. 01	<p>Based on review of "Disaster Manual: Use of Fire Extinguisher" documentation with the Maintenance Director during record review from 9:10 a.m. to 11:50 a.m. on 10/06/15, the written fire safety plan did not address the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 1:40 p.m. on 10/06/15, one K class fire extinguisher was located in the kitchen. Based on interview at the time of record review and of the observation, the Maintenance Director acknowledged the written fire safety plan for the facility did not address the use of the K class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system.</p> <p>3.1-19(a)</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 record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was</p>	K 0062	<b>K 062 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient</b>	11/15/2015
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	<p>clear of blockage once an internal pipe inspection revealed obstruction. NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems at 10-2.3 requires a complete flushing program shall be conducted by qualified personnel. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of SafeCare's "Service Notes" documentation dated 03/26/14 with the Maintenance Director during record review from 9:10 a.m. to 11:50 a.m. on 10/06/15, an internal pipe inspection conducted on 03/26/14 for the facility's sprinkler system stated "Performed Internal Pipe inspection on fire sprinkler system and found that system is full of rust and debris. Recommend that fire sprinkler system be flushed. Send quote to flush fire sprinkler system." In addition, review of SafeCare's "Purchase Agreement" documentation dated 04/29/14 provided a quote to perform a complete dry sprinkler system hydraulic flush of all sprinkler feed mains, cross mains, and branch lines of the entire facility. Based on interview at the time of record review, the Maintenance Director stated sprinkler system flushing had not been performed</p>		<p><b>practice;</b></p> <p>1. No residents have been affected by the deficient practice, however, we are requesting a waiver until spring and weather is more conducive to the pipe flushing process.</p> <p>2. No residents have been affected by the deficient practice.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</b></p> <p>1. All residents in this home have the potential to be affected by the deficient practice. The every fifth year preventive maintenance schedule will be updated to include the internal pipe inspection. We are requesting a waiver to wait until spring when the weather is more conducive to the pipe flushing process.</p> <p>2. All residents in this home have the potential to be affected by the same deficient practice. The pump will be pulled and repaired.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>1. The Contractor during his every fifth year inspection of the internal pipe will bring forward any issues and will inform the Maintenance Director of any needed pipe maintenance in their report.</p>				

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	<p>since SafeCare's internal pipe inspection and flushing quote and acknowledged sprinkler system flushing has not been performed or scheduled on or after 03/26/14.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler system's fire pump was continuously maintained in reliable operating condition. NFPA 25, 5-3.3.1 states an annual test of each pump assembly shall be conducted under minimum, rated and peak flows of the fire pump. Section 1-4.4 states the owner or occupant promptly shall correct or repair deficiencies, damaged parts, or impairments found while performing the inspection, test, and maintenance requirements of this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. Section 1-8 states records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p>		<p>2. The Contractor during their annual inspection will bring forward any issues and will inform the Maintenance Director of any needed maintenance for the pump in their report. The annual preventive maintenance schedule will be updated to include the pump inspection.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place;</b></p> <p>1. The Contractor during their every fifth year inspection will bring forward any issues and will inform the Maintenance Director of any needed pipe maintenance. The results of the inspection report will be brought to the current monthly safety meeting and to the monthly QAA meeting.</p> <p>2. The Contractor during their inspection will bring forward any issues and will inform the Maintenance Director of any needed pump maintenance. The results of the inspection report will be brought to the monthly safety meeting and the monthly QAA meeting.</p> <p><b>Completion Date:</b></p> <p>1. Requesting a waiver due to weather not being conducive to flushing the sprinkler pipe at this time. The Contractor, Safe Care, will complete flush of system by May 31, 2016.</p> <p>2. 11-15-2015</p>		

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K 0064	<p>Based on review of Peerless Midwest Inc. letter dated 03/26/15 during record review with the Maintenance Director from 9:10 a.m. to 11:50 a.m. on 10/06/15, the annual fire pump inspection for the sprinkler system on-site tank storage water supply "noted that the pump has acquired a bad vibration, and there are traces of brass in the packing gland discharge. It would be prudent to have this pump pulled for evaluation and repairs." In addition, review of Peerless' "Annual Electric Motor Driven Fire Pump Maintenance" documentation dated 03/19/15 stated "No" to "Is the pump free from any unusual noise or vibration when running?" Based on interview at the time of record review, the Maintenance Director stated the fire pump has not been repaired or replaced following Peerless' March 2015 inspection and acknowledged documentation of fire pump repair or replacement was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 1:40 p.m. on 10/06/15, one fire pump for the sprinkler system on-site tank storage water supply was noted in a detached building.</p> <p>3.1-19(b) NFPA 101</p>			

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SS=D Bldg. 01	<p><b>LIFE SAFETY CODE STANDARD</b> Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect three staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 1:40 p.m. on</p>	K 0064	<p><b>K 064</b> <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</i> No Residents were found to have been affected by this deficient practice. A placard was placed in a conspicuous place near the Class K Extinguisher.</p> <p><i>How other residents having the potential to be affected by the same deficient practice;</i> All Residents in this home have the potential to be affected by this deficient practice.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</i> A placard was conspicuously placed near the Extinguisher (labeled for Class K fires) which states the fire protection system shall be activated prior to using the fire extinguisher (labeled for Class K fires). The weekly preventive maintenance schedule will be updated to include checking the placard for compliance.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place;</i> The weekly preventive maintenance schedule will be updated to include</p>	10/21/2015	

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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT LEBANON			STREET ADDRESS, CITY, STATE, ZIP CODE 1585 PERRY WORTH RD LEBANON, IN 46052		
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K 0076 SS=E Bldg. 01	<p>10/06/15, a portable K Class fire extinguisher was located in the kitchen and a placard was not conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Based on interview at the time of observation, the Maintenance Director acknowledged a placard was not conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside.</p>		<p>the placard conspicuously placed near the extinguisher (labeled for Class K fires) which states the fire protection system shall be activated prior to using the fire extinguisher (labeled for Class K fires). The results of the preventive maintenance schedule weekly check will be reported in the monthly safety meeting and will also be reported in the monthly QAA meeting.</p> <p><b>Completion Date:</b> 10-21-2015</p>		

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	<p>NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3,000 cubic feet are vented to the outside by a dedicated mechanical ventilation system or by natural venting. If natural venting is used, the vent opening or openings shall be a minimum of 72 square inches in total free area. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 1:40 p.m. on 10/06/15, the oxygen storage and transfilling room which was used to store five liquid oxygen containers was not provided with continuous mechanical ventilation. An operating mechanical vent was observed in place on the ceiling in the room but the mechanical vent was turned off by the use of a wall mounted switch and did not turn back on after five attempts of flipping the wall mounted switch. Based on interview at the time of observation, the Maintenance Director acknowledged the oxygen storage and transfilling room was not provided with continuous mechanical ventilation or</p>	K 0076	<p><b>K 076</b></p> <p><b><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</i></b></p> <p>No residents identified by the surveyor were affected by the deficient practice. The ventilation to the oxygen storage location was repaired with continuous mechanical ventilation.</p> <p><b><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</i></b></p> <p>All residents in this home have the potential to have been affected by this deficient practice. The ventilation to the oxygen storage location was repaired with continuous mechanical ventilation.</p> <p><b><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</i></b></p> <p>The weekly preventive maintenance schedule will be updated to include the oxygen storage location for the properly working continuous ventilation system check.</p> <p><b><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place;</i></b></p> <p>The weekly preventive maintenance checks for the oxygen storage location will be reported in the</p>	10/06/2015	

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K 0130 SS=F Bldg. 01	with natural vent openings of greater than 72 square inches in total free area.  3.1-19(b)  NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 1. Based on record review, observation and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors were in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written	K 0130	monthly safety meeting and the monthlyQAA meeting. <b>Completion Date;</b> 10-6-2015  <b>K 130</b> <b>What corrective action(s) will be accomplished for those residents foundto have been affected by the deficient practice;</b> 1. No residents were affected by the deficient practice.The dietary rolling fire door was inspected 10-7-2015. 2.No residentswere affected. The battery smoke detectorsare removed from the resident rooms. <b>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what correctiveaction(s) will be taken;</b> 1. All residents in this home have the potentialto be affected by this deficient practice. The rolling fire door in the dietary department will be checked	10/31/2015	

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	<p>record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 20 residents, staff and visitors in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on review of Safe Care's "Service Call" documentation dated 09/26/14 with the Maintenance Director during record review from 9:10 a.m. to 11:50 a.m. on 10/06/15, documentation of kitchen rolling fire door inspection and testing within the most recent twelve month period was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 1:40 p.m. on 10/06/15, one metal rolling fire door protecting the opening from the kitchen to the Main Dining Room was noted. SafeCare had affixed an inspection tag to the rolling fire door indicating the most recent inspection was 09/26/15. Based on interview at the time of record review and observation, the Maintenance Director acknowledged documentation of kitchen rolling fire door inspection and testing within the most recent twelve month period was not available for review.</p> <p>3.1-19(b)</p>		<p>annually.</p> <p>2.Allresidents in this home have the potential to be affected by this deficientpractice. The battery smoke detectorshave been removed</p> <p><b>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur;</b></p> <p>1. The annual preventive maintenance schedulewill be updated to trigger notification to the Maintenance Director one monthprior to the annual inspection date, for the rolling dietary door, to ensurethe inspection will be timely.</p> <p>2. The battery smoke detectors have been removedfrom the resident's rooms.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficientpractice will not recur, ie, what quality assurance program will be put into place;</b></p> <p>1. The Maintenance Director will monitor theannual preventive maintenance schedule to ensure the rolling dietary door isinspected timely. The rolling dietarydoor inspection will be reported in the next safety meeting and the QAmeeting.</p> <p>2. The battery operated smoke detectors have beenremoved from the resident rooms. Thebattery smoke detectors will be reported at monthly safety meeting and the monthly QAA</p>		

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	<p>2. Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 32 of 32 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 all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Resident Room Battery Operated Smoke Detectors" documentation with the Maintenance Director during record review from 9:10 a.m. to 11:50 a.m. on 10/06/15, documentation of an itemized list by location of annual battery operated smoke detector cleaning for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated the aforementioned monthly battery operated smoke detector testing documentation only includes functional testing of the detectors and acknowledged documentation of an itemized list by location of annual battery operated smoke detector cleaning for the most recent twelve month period was not</p>		<p>meeting. <b>Compliance Date;</b> 10-31-2015</p>	

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	<p>available for review. Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 1:40 p.m. on 10/06/15, Kidde Ionization Smoke Alarm Model 0915 battery operated smoke detectors are installed in each of 32 resident sleeping rooms in the facility. Manufacturer's instructions affixed to the back of the battery operated smoke detector in resident Room 111 and in resident Room 122 stated to clean the detector's sensor annually. In addition, manufacturer's instructions affixed to the back of the battery operated smoke detector in resident Room 111 and in resident Room 122 stated to replace the detector 10 years after the manufacture date which was listed as June 2003. Based on interview at the time of the observations, the Maintenance Director acknowledged annual battery operated smoke detector cleaning documentation for the most recent twelve month period was not available for review and acknowledged at least two resident room smoke detectors had not been replaced 10 years after the manufacture date.</p> <p>3.1-19(a)</p>			

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K 0143 SS=E Bldg. 01	<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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage and transfilling rooms was provided with continuous mechanical ventilation. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 1:40 p.m. on 10/06/15, the oxygen storage and</p>	K 0143	<p><b>K 143</b> <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</i></p> <p>No residents identified by the surveyor were affected by the deficient practice. The ventilation to the oxygen storage location was repaired with continuous mechanical ventilation.</p> <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</i> All residents in this home have the potential to have been affected by this deficient</p>	10/06/2015

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K 0147 SS=E Bldg. 01	<p>transfilling room which was used to store five liquid oxygen containers was not provided with continuous mechanical ventilation. An operating mechanical vent was observed in place on the ceiling in the room but the mechanical vent was turned off by the use of a wall mounted switch and did not turn back on after five attempts of flipping the wall mounted switch. Based on interview at the time of observation, the Maintenance Director acknowledged the oxygen storage and transfilling room was not provided with continuous mechanical ventilation.</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 cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section</p>	K 0147	<p>practice. The ventilation to the oxygen storage location was repaired with continuous mechanical ventilation.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> The weekly preventive maintenance schedule will be updated to include the oxygen storage location for the properly working continuous ventilation system check. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place;</b> The weekly preventive maintenance checks for the oxygen storage location will be reported in the monthly safety meeting and the monthly QAA meeting. <b>Completion Date;</b> 10-6-2015</p> <p><b>K147 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The resident identified by the surveyor immediately had the oxygen concentrator plugged into the fixed wiring provided in the room. <b>How other residents</b></p>	10/07/2015	

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	<p>4.5.6 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 1999 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 7-5.2.2.1 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 16 residents, staff and visitors in the vicinity of Room 109.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 1:40 p.m. on 10/06/15, an Invacare oxygen concentrator was plugged into a power</p>		<p><b>having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</b> All residents living in this home have the potential to be affected by this deficient practice. The weekly preventive maintenance schedule will be updated to include inspecting each room assuring no power strips are allowed to power medical equipment. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> The weekly preventive maintenance schedule will be updated to include assuring no power strips are powering medical equipment. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place;</b> The weekly preventive maintenance schedule will be updated to include assuring no power strips are powering medical equipment. The results of the preventive maintenance schedule will be included in the monthly safety meeting and results will be reported in the QAA meeting monthly. <b>Completion Date:</b> 10-7-2015</p>		

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	strip which was located under the resident bed nearest the corridor door in Room 109. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned location.  3.1-19(b)				