

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2016
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NAME OF PROVIDER OR SUPPLIER LAKELAND REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542
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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: 03/17/16</p> <p>Facility Number: 000491 Provider Number: 155495 AIM Number: 100291230</p> <p>At this Life Safety Code survey, Lakeland Rehabilitation and Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This 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, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 60 and had a census of 54 at</p>	K 0000	The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.	
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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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K 0021 SS=D Bldg. 01	<p>the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility has a shed providing facility services including the storage of maintenance supplies and lawn equipment that was not sprinklered. The facility has two additional off site storage units. One unit is used for the storage of maintenance parts and supplies and the other is used for the storage of activity supplies. The off site storage unit were not sprinklered.</p> <p>Quality Review completed on 03/23/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2</p> <p>Door assemblies in vertical openings are of</p>						

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K 0029 SS=E Bldg. 01	<p>an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Kitchen, a hazardous area, was only held open by a device that would release with the fire alarm activation. This deficient practice could affect staff and at least 28 residents.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Director of Plant Operations on 03/17/16 at 1:06 p.m., the Kitchen corridor door was propped open with a sponge under the door preventing the door from self-closing if the fire alarm was to be activated. Based on interview at the time of observation, the Executive Director and the Director of Plant Operations acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire</p>	K 0021	<p>1. Sponge was removed immediately on 3-17-16. No residents were affected by this practice. 2. Environmental tour of the campus completed, no other concerns noted. No residents were affected. 3. Executive Director/Designee will tour the facility weekly for 3 months and monthly for 3 months. 4. Findings from Executive Director/Designee from tour will be reviewed in QA monthly x 6 months. After 6 months and 100% compliance is obtained, further monitoring will be completed as recommended by the QA committee. 5. Date of Compliance: 4-16-2016</p>	04/16/2016			

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	<p>extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Medical Records and 1 of 1 Therapy storage area greater than 50 square feet, a hazardous area, was provided with self-closer and would latch into the frame. This deficient practice could affect staff and up to 6 residents in the Therapy area.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Director of Plant Operations on 03/17/16 at 12:09 p.m. then again at 12:13 p.m., the Medical Records room contained twenty fire large cardboard boxes filled with medical record files. The corridor door in the Medical Records storage office did not have a self-closing device installed on the door. Then again, the Therapy storage room contained many large decoration items stacked on top of one another and at least fifteen large cardboard boxes filled with decorations. The corridor door to the Therapy storage room did not have a self-closing device installed on the</p>	K 0029	<p>1. Self closing devices installed on Medical records and therapy storage doors. No resident affected. 2. Toured facility to ensure no other doors were affected by this deficient practice. No residents affected. 3. Executive Director and/or Designee will tour the facility monthly for 6 months to ensure no rooms are affected by this deficient practice. 4. Findings from executive director and/or designee tour will be reviewed at the monthly QA meeting X 6 months. After 6 months and 100% compliance, further monitoring will be completed as recommended by QA committee. 5. Date of Compliance: 4-16-2016</p>	04/16/2016

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K 0045 SS=E Bldg. 01	<p>door. Based on interview at the time of each observation, the Executive Director and the Director of Plant Operations acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8</p> <p>1. Based on observation and interview, the facility failed to provide exterior emergency lighting for 1 of 3 Therapy exits. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect staff and up to 6 residents.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Director of Plant Operations on 03/17/16 at 12:26 p.m., the North Therapy exit did not have any lights provided for the exit discharge to a public way. Based on interview at the time of observation, the Executive Director and the Director of Plant</p>	K 0045	<p>1. Two-bulb fixtures fixture will be added to North Therapy exit, Therapy entrance exit, and Therapy back service exit. No residents were affected. 2. Facility tour completed to ensure no other doors were affected by this deficient practice. No residents affected. 3. Executive Director and/or Designee will tour the facility to ensure no other doors are affected by this deficient practice. 4. Once all doors are inspected for compliance, no further monitoring will be necessary. 5. Date of Compliance: 4-16-2016</p>	04/16/2016	

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K 0046 SS=C Bldg. 01	<p>Operations acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the lighting for 2 of 4 Therapy exits means of egress were arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect staff and up to 6 residents.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Director of Plant Operations on 03/17/16 at 12:01 p.m. then again at 12:04 p.m., the "Therapy Entrance" exit discharge had only one bulb outside. Then again, the "Therapy Back Service" exit discharge had only one bulb outside. Based on interview at the time of each observation, the Executive Director and the Director of Plant Operations acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9.</p>			

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	<p>18.2.9.1, 19.2.9.1.</p> <p>Based on record review and interview; the facility failed to ensure 1 of 1 Mechanical Room battery operated emergency lights in the facility was maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. 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 could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the the Executive Director and the Director of Plant Operations on 03/17/16 at 11:26 a.m., no documentation prior to January 2015 for the battery operated emergency light in the Mechanical Equipment Room was available for review. Based on interview at the time of observation, the the Executive Director and the Director of Plant Operations acknowledged the aforementioned condition.</p>	K 0046	<p>1. Moving forward, we will ensure proper documentation is in place for the emergency lighting equipment. No residents were affected. 2. No residents were affected by this deficient practice. 3. Executive Director and/or designee will monitor inspections located in Plant Operations manual monthly. 4. Plant Operations Manual will be brought to QA monthly for review for 6 months. After 6 months and 100% compliance, further monitoring will be completed as recommended by QA committee. 5. Date of Compliance: 4-16-2016</p>	04/16/2016			

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K 0050 SS=F Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 2 of the last 4 calendar quarters. This deficient practice could affect all staff and residents.</p> <p>Findings include: Based on record review with the Executive Director and the Director of Plant Operations of the fire drill reports titled "Monthly Fire Drill Report" on 03/17/16 at 11:29 a.m., the documentation for a first shift fire drill for the first quarter of 2016 and the second and third shift fire drill for the second quarter of 2015 was not available for review. Based on interview at the</p>	K 0050	<p>1. First shift fire drill completed for first quarter 2016. Moving forward, we will ensure fire drills are completed in a timely manner and logged with proper documentation. No residents were affected. 2. No residents were affected by this deficient practice. 3. Executive Director and/or designee will monitor fire drills and documentation monthly for 6 months. 4. Findings will be reviewed in QA for 6 months. After 6 months and 100% compliance, further monitoring will be completed as recommended by QA committee. 5. Date of Compliance: 4-16-16</p>	04/16/2016

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K 0051 SS=D Bldg. 01	<p>time of record review, the Executive Director and the Director of Plant Operations acknowledged the lack of documentation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoke detector in the Laundry was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems,</p>	K 0051	1. Smoke detector has been moved more than 24 inches away from vent. No residents were affected. 2. Facility tour completed to ensure no other smoke detectors were affected by this deficient practice. Any	04/16/2016	

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K 0052 SS=F Bldg. 01	<p>detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Director of Plant Operations on 03/17/16 at 12:56 p.m., the Laundry room had a smoke detector located eighteen inches away from an HVAC vent. Based on interview at the time of observation, the Executive Director and the Director of Plant Operations acknowledged the aforementioned condition and provided the measurement. 3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm system was maintained in accordance with the applicable requirements of NFPA 72, National Fire</p>	K 0052	<p>findings, were fixed at that time.</p> <p>3. Executive Director and/or Designee will tour the facility to ensure no other smoke detectors were affected by this deficient practice. 4. Findings will be reported to QA, once at 100% compliance is completed, no further monitoring will be necessary. 5. Date of Compliance: 4-16-2016</p> <p>1. Fire Alarm inspection company contacted to receive copy of sensitivity test. No residents affected. Moving forward, we will ensure proper documentation remains in plant operations manual. No residents affected. 2.</p>	04/16/2016			

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	<p>Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test 		<p>No residents were affected by this deficient practice. 3. Executive Director and/or designee will ensure documentation of sensitivity test is in plant operations manual. 4. Findings will be brought to QA. Once 100% compliance, no further monitoring will be necessary. 5. Date of Compliance: 4-16-2016</p>				

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K 0056 SS=D Bldg. 01	<p>methods approved by the authority having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all staff, resident, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Executive Director and the Director of Plant Operations on 03/17/16 between 2:02 p.m. and 2:13 p.m., no sensitivity test documentation was available for review. Based on an interview at the time of record review, the Executive Director and the Director of Plant Operations acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations</p>				

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	<p>prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>Based on observation and interview, the facility failed to ensure the spray pattern for 3 of 3 sprinkler in the Director of Environmental Service was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Table 5-6.5.1.2 states that distance between a sprinkler head an obstruction less than 1 foot away cannot be lower than the sprinkler head deflector. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Director of Plant Operations on 03/17/16 at 12:31 a.m., the spray pattern for the three sprinkler heads in the Director of Environmental Service storage area was located next to ceiling box lights. Measurements showed the sprinkler head was three inches away from the ceiling light. The ceiling light were measured to be a half an inch lower than the sprinkler head deflector. Based on interview at the time of observation,</p>	K 0056	<p>1. Three ceiling lights will be replaced in Director of Environmental Services storage area in order to achieve compliance. No residents were affected. 2. Facility was toured to ensure no other areas were affected. No residents were affected by this deficient practice. 3. Executive Director and/or designee will tour the facility to ensure no other areas are affected, and ceiling lights are replace in Director of Environmental Services storage area. 4. Findings will be reported to QA. Once 100% compliance is obtained, no further monitoring will be necessary. 5. Date of Compliance: 4-16-2016</p>	04/16/2016

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NAME OF PROVIDER OR SUPPLIER LAKELAND REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542
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K 0062 SS=F Bldg. 01	<p>the Executive Director and the Director of Plant Operations acknowledged the abovementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler system components was inspected quarterly for 3 of 4 calendar quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors.</p>	K 0062	<p>1. Contacted sprinkler inspection company to obtain copies of sprinkler systems inspection report and internal pipe inspection documentation. No residents affected. Moving forward, we will ensure proper sprinkler systems inspection and internal pipe inspection documentation is kept in the plant operations manual. 2. No residents were affected by this deficient practice. 3. Executive Director and/or designee will ensure sprinkler systems inspections and internal pipe inspection documentation is kept in plant operations manual in timely manner. 4. Findings will be reported to QA for 6 months. After 6 months and 100% compliance, further monitoring will be completed as recommended by QA committee. 5. Date of Compliance: 4-16-2016</p>	04/16/2016

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	<p>Findings include:</p> <p>Based on record review with the Executive Director and the Director of Plant Operations on 03/17/16 from 2:02 p.m. to 2:13 p.m., there was no second, third or fourth quarter of 2015 sprinkler system inspection report available. Based on interview at the time of record review, the Executive Director and the Director of Plant Operations acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient</p>			

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K 0130 SS=E Bldg. 01	<p>practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on record review with the Executive Director and the Director of Plant Operations on 03/17/16 between 2:02 p.m. and 2:13 p.m., no internal pipe inspection documentation was available for review. Based on interview at the time of record review, the Executive Director and the Director of Plant Operations acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation and interview, the facility failed to ensure the penetration in 1 of 3 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic</p>	K 0130	<p>1. Dry wall re-installed to ensure area has at least a 1 hour fire resistance rating. No residents were affected. 2. Facility was toured to ensure that all areas have been inspected for penetrations. No residents were affected by this deficient practice. 3. Executive Director and/or designee will tour the facility monthly to ensure that all dry wall is in place. 4. Findings will be reported to QA monthly for 6 months. After 6 months and</p>	04/16/2016	

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	<p>tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect staff and at least 30 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Executive Director and the Director of Plant Operations on 03/17/16 at 1:49 p.m., the Dining Room fire barrier had a three foot by two feet penetration of all</p>		<p>100% compliance, further monitoring will be completed as recommended by QA committee.</p> <p>5. Date of Compliance: 4-16-2016</p> <p>1. Inspection company contacted to obtain copy of current inspection certificate. No residents were affected. Moving forward, we will ensure current inspection certificate is in place.</p> <p>2. No resident were affected by this deficient practice. 3. Executive Director and/or designee will ensure copy of current inspection certificate is obtained. 4. Current inspection certificates will be reviewed by QA monthly for 6 months, and located in mechanical room. 5. Date of Compliance: 4-16-2016</p>		

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	<p>layers of drywall removed. Based on interview at the time of observation, the Executive Director and the Director of Plant Operations acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 water heaters had a current inspection certificate to ensure the water heater was in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of residents. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Director of Plant Operations on 03/17/16 at 12:36 p.m., one of the two water heaters certificate expired on 04/16/14. Based on interview at the time of observation, the Executive Director did not know about the expired certificate and acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>			

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K 0147 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1</p> <p>Based on observation and interview, the facility failed to maintain an electrical outlet in 1 of 1 Laundry room. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Director of Plant Operations on 03/17/16 on 12:56 p.m., an outlet was missing a cover in the Laundry room. Based on interview at the time of observation, the Executive Director and the Director of Plant Operations acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0147	<p>1. Outlet cover replaced in laundry room. No residents were affected. 2. Facility tour completed to ensure no other outlet covers missing. Any concerns to be addressed at that time. 3. Executive Director and/or designee to complete facility tour monthly for 6 months to ensure all outlet covers are in place. 4. Findings will be reported to QA for 6 months. After 6 months and 100% compliance, further monitoring will be completed as recommended by QA committee. 5. Date of Compliance: 4-16-2016</p>	04/16/2016			