STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING	(X3) DATE SURVEY COMPLETED 02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUNSTER MED-INN	7935 CALUMET AVE MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 03	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). Survey Date: 02/08/16 Facility Number: 000056 Provider Number: 155131 AIM Number: 100289450 At this Life Safety Code survey, Munster Med-Inn 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. This six story facility with a basement was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Battery operated smoke detectors are installed in all resident rooms. The facility has the capacity for	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	225 and had a census of 189 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review on 02/12/16 by Lex Brashear, LSC Specialist			
K 0014 SS=E Bldg. 03	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower half of corridor walls, not exceeding 4ft in height, may have a Class C flame spread rating. 10.2, 18.3.3.1, 18.3.3.2, NFPA TIA 00-2 Based on observation, interview and record review; the facility failed to ensure materials used as an interior finish for 1 of 2 Ground Floor corridors had a flame spread rating of Class A or Class B. LSC 101 10.2.3.2 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke	K 0014	Please accept the following as the facility's credibleallegation of compliance. This plan of correction does not constitute anadmission of guilt or liability by the facility and is submitted only in responseto the regulatory requirement. What corrective actions willbe accomplished for those residents found to have affected by the deficient practice? THE MANUFACTURERS FLAME SPREADRATING WAS LOCATED AND PUT IN THE FLAME SPREAD RATING BINDER (ATTACHED). How the facility will identifyother resident having the potential to be	02/22/2016

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	development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect staff, visitors, and at least 10 residents. Findings include: Based on observation with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 between 11:08 a.m. and 3:40 p.m., there was a plastic material designed to look like siding installed on the corridor walls near the Entrance as an interior finish. Based on interview at the time of observation, the Corporate Property		affected by the same deficientpractice and what corrective action will be taken; A FACILITY WALK THRU WASCOMPLETED BY THE MAINTENANCE MANAGER TO IDENTIFY ANY OTHER POTENTIAL DEFICIENCY.NO OTHER DEFICENCIES FOUND. What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur: THE MAINTENANCE MANAGER/DESIGNEEWILL AUDIT THE BUILDING MONTHLY TO ENSURE THAT THE INTERIOR FINISHES HAVE THEREQUIRED FLAME SPREAD RATING INFORMATION. How will the corrective actionbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance programs will be put into place; THE MAINTENANCE MANAGER WILLPRESENT THE FINDINGS OF THE MONTHLY AUDITS TO THE SAFETY COMMITTEE QUARTERLYFOR 2 QUARTERS.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING	(X3) DATE SURVEY COMPLETED 02/08/2016
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321	

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	Manager, Corporate Engineer, and Building Manager acknowledged the aforementioned condition and acknowledged no documentation was available for review. 3.1-19(b)			
K 0017 SS=E Bldg. 03	NFPA 101 LIFE SAFETY CODE STANDARD Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be 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, 18.3.6.4, 18.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 1 2nd floor Janitor's closet was separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by an automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice	K 0017	Please accept the following as the facility's credibleallegation of compliance. This plan of correction does not constitute anadmission of guilt or liability by the facility and is submitted only inresponse to the regulatory requirement. What corrective actions willbe accomplished for those residents found to have affected by the deficient practice? THE IDENTIFIED JANITORS CLOSETFIRE RATED DOOR WILL BE RE-INSTALLED ALONG WITH A REQUIRED DOOR CLOSER. How the facility will identifyother resident having the potential to be affected by the same deficientpractice and what corrective action will be taken; A FACILITY WALK THRU	03/09/2016

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	could affect staff and at least 20 residents. Findings include: Based on an observation with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 at 1:37 p.m., the 2nd floor Janitor's closet had no door on the door frame. The room is not viewable from the nurse's station. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because the 2nd floor Janitor's closet was not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of observation, the Corporate Property Manager, Corporate Engineer, and Building Manager acknowledged the aforementioned condition. 3.1-19(b)		WASCOMPLETED BY THE MAINTENANCE MANAGER TO IDENTIFY ANY OTHER POTENTIAL DEFICIENCY.NO OTHER DEFICENCIES FOUND What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur: THE FACILITY IS COMMITED TO MAKE SURE NO OTHERJANITOR CLOSET DOORS ARE REMOVED. How will the corrective actionbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance programs will be put into place; THE MAINTENANCE MANAGEROR DESIGNEE WILL AUDIT THE DOOR DURING PREVENTIVE MAINTENANCE ROUNDS TO ENSUREPROPER CLOSING	
K 0025 SS=D Bldg. 03	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5 Based on observation and interview, the	K 0025	Please accept the following as	02/22/2016

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	facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 1 ceiling wall were protected to maintain the smoke resistance. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke wall shall be filled with a material capable of maintaining the smoke resistance of the smoke wall or be protected by an approved device designed for the specific purpose. This deficient practice could affect staff only. Findings include: Based on observations with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 between 1:37 p.m. to 2:02 p.m., the following ceiling penetrations were discovered: a) a one and a half inch by seven inch gap around the ceiling exit sign by resident room 325 b) 23 out of 55 ceiling tiles were missing in the Therapy Computer room c) one and a quarter inch penetration in the 1st floor Soiled Utility room Based on interview at the time of each observation, the Corporate Property Manager, Corporate Engineer, and		the facility's credibleallegation of compliance. This plan of correction does not constitute anadmission of guilt or liability by the facility and is submitted only inresponse to the regulatory requirement. What corrective actions willbe accomplished for those residents found to have affected by the deficient practice? A) THE CEILING TILE WASREPLACED AROUND THE EXIT SIGN BY ROOM 325 ELIMINATING THE DEFICENT GAP TO MEETTHE REQUIREMENTS. B) THE 23 CEILING TILES THATWERE MISSING WERE INSTALLED. C) THE CEILING TILE WASREPLACED IN THE 1ST FLOOR SOILED UTILITY ROOM ELIMINATING THE DEFICENTGAP TO MEET THE REQUIREMENTS. How the facility will identifyother resident having the potential to be affected by the same deficientpractice and what corrective action will be taken; THE MAINTENANCE MANAGER/DESIGNEEWILL MONITOR ALL FACILITY SPACES FOR PROPER CEILING TILE PLACEMENT DURINGPREVENTATIVE ROUNDS. ALL OUTSIDE VENDORS WILL BE INSTRUCTED TO FILL ALLPENETRATIONS AND REPLACE ALL DISPLACED	

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	Building Manager acknowledged aforementioned condition and provided the measurements. 3.1-19(b)		CEILING TILES AFTER ANY REPAIR HAS BEENCOMPLETED. What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur: THE MAINTENANCE MANAGER WILLAUDIT 10 ROOMS PER DAY FOR ANY IMPROPERLY FITTED OR MISSING CEILING TILES. How will the corrective actionbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance programs will be put into place; THE MAINTENANCE MANAGER WILL REPORTTHE AUDIT FINDINGS TO THE ADMINISTATOR AND SAFETY COMMITTEE EACH MONTH FOR 3MONTHS.	
K 0027 SS=E Bldg. 03	NFPA 101 LIFE SAFETY CODE STANDARD Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1 3/4 inch thick solid bonded core wood. 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 shall be arranged so that each door swings in an opposite direction. Doors shall be 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 Based on observation and interview, the facility failed to ensure 2 of 3 set of fire	K 0027	Please accept the following as the facility's credibleallegation of	02/22/2016

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	barrier doors and 2 of 7 set of smoke barrier doors would close to form a smoke resistant barrier. This deficient practice could affect staff and at least 5 residents. Findings include: Based on observation with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 between 2:20 p.m. to 3:15 p.m., the following barrier doors would not close to form a smoke resistive barrier: a) Ground floor Lobby fire barrier doors left a one eighth gap b) Ground floor smoke barrier left a half inch gap c) Lower Level fire barrier doors left a three eighths inch gap d) Lower Level smoke barrier doors had a laundry cart preventing the doors from closing. When the cart was removed, the smoke barrier doors still left a quarter inch gap. Based on interview at the time of each observation, the Corporate Property Manager, Corporate Engineer, and Building Manager acknowledged each aforementioned condition and provided the measurements. 3.1-19(b)		compliance. This plan of correction does not constitute anadmission of guilt or liability by the facility and is submitted only inresponse to the regulatory requirement. What corrective actions willbe accomplished for those residents found to have affected by the deficient practice? NEW DOOR ASTRAGALS WEREINSTALLED ON ALL FOUR IDENTIFIED DEFICIENT FIRE BARRIER DOORS. THE LAUNDRYSTAFF HAVE BEEN INSERVICED ON NOT TO PLACE ANY OBSTACLES IN THE PATH OF THEFIRE BARRIER DOOR CLOSING. How the facility will identifyother resident having the potential to be affected by the same deficientpractice and what corrective action will be taken; ALL OTHER FIRE DOORS WERETESTED AND FOUND TO BE IN COMPLIANCE. What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur: THE MAINTENANCE MANAGER ORDESIGNEE WILL AUDIT THE FIRE DOORS DURING FIRE DRILLS TO ENSURE PROPER CLOSING. How will the corrective actionbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance programs will be put into place;	

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			THE MAINTENANCE MANAGER ORDESIGNEE WILL REPORT THE AUDIT RESULTS ON A MONTHLY BASIS TO THE SAFETYCOMMITTEE FOR 3 MONTHS.	
K 0029 SS=D Bldg. 03	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Business office, 1 of 1 Basement Linen storage, and 1 of 1 Basement Medical Storage room greater than 50 square feet, a hazardous area, was provided with self-closer and would latch into the frame. This deficient practice was not in a resident care but could affect facility staff. Findings include: Based on observation with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 between 2:29 p.m. and 3:37 p.m., a) the Business office contained a six foot by nine foot file cabinet with the doors removed full of documentation, at least	K 0029	Please accept the following as the facility's credibleallegation of compliance. This plan of correction does not constitute anadmission of guilt or liability by the facility and is submitted only inresponse to the regulatory requirement. What corrective actions willbe accomplished for those residents found to have affected by the deficient practice? 1.A DOORSELF CLOSER WAS INSTALLED ON THE BUSINESS OFFICE DOOR. 2.THE BASEMENTLINEN STORAGE DOOR CLOSER HAS BEEN ADJUSTED TO PROPERLY LATCH. 3.A DOORSELF CLOSER WAS INSTALLED ON THE BASEMENT MEDICAL RECORDS DOOR. How the facility will identifyother	02/22/2016

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	forty cardboard boxes of supplies, and other combustible furniture. The corridor door did not have a self-closer installed. b) the Basement Linen storage had a self-closers installed on both doors but the door failed to close and latch because the doors caught up on the door coordinator. c) the Basement Medical Records room contained at least fifty cardboard boxes containing medical records. The corridor room door did not have a self-closer installed. Based on interview at the time of each observation, the Corporate Property Manager, Corporate Engineer, and Building Manager acknowledged each aforementioned condition. 3.1-19(b)		resident having the potential to be affected by the same deficientpractice and what corrective action will be taken; THE MAINTENANCE MANAGER/DESIGNEEWILL AUDIT THE OXYGEN STORAGE LOCATIONS WEEKLY AND REPORT FINDINGS TO THESAFETY COMMITTEE FOR THREE MONTHS What measures will be put into place or whatsystemic changes will be made to ensure that the deficient practice does notrecur: MAINTENANCE MANAGER ORDESIGNEE WILL AUDIT TEN DOORS MONTHLY THAT REQUIRE A DOOR CLOSER. How will the corrective actionbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance programs will be put into place; MAINTENANCE MANAGER WILLPRESENT THE MONTHLY AUDITS TO THE SAFETY COMMITTEE ON A QUARTERLY BASIS FOR 2QUARTERS.	
K 0048 SS=F Bldg. 03	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. 18.7.1.1, 19.7.1.1 Based on record review and interview, the facility failed to provide a written plan that addressed all components for the protection of 189 of 189 residents.	K 0048	Please accept the following as the facility's credibleallegation of compliance. This plan of correction does not constitute anadmission of guilt or liability by	03/04/2016

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	LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on a record review with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 at 10:51 a.m., the "Fire Safety/Fire Response" plan failed to the following: (4) response to alarms for their battery operated smoke alarms (6) Evacuation of smoke compartment failed to include acknowledgement of two sets of doors not in a smoke/fire barrier on the Ground Floor level that can be confused as a smoke barrier. Evacuations beyond these two sets of doors would still leave residents in the same smoke compartment.		the facility and is submitted only in response to the regulatory requirement. What corrective actions willbe accomplished for those residents found to have affected by the deficient practice? 1.) THE ADDITION OF APOLICY/PROCEDURE REGARDING WHAT THE RESPONSE TO THE BATTERY OPERATED SMOKE DETECTORS WILL BE ADDED TO THE FIRE SAFETY PLAN. 2.) THE ADDITION OF APOLICY/PROCEDURE REGARDING A VERTICAL EVACUATION FOR THE FACILITIES FIVE FLOORSWILL BE ADDED TO THE FIRE SAFETY PLAN. 3.) THE EXISTING EXIT SIGN WAS MOVED TO THE MAIN HALL AND ADDED A “THIS IS NOT AN EXIT” SIGN BY THE IDENTIFIED SMOKE BARRIER DOORS. How the facility willidentify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; A FACILITY WALK THRU WAS COMPLETEDBY THE MAINTENANCE MANAGER TO IDENTIFY ANY OTHER AREAS NOT MEETING THEREQUIREMENT. NO OTHER DEFICINCIES NOTED How will the correctiveaction be monitored to ensure the deficient practice will not recur, i.e. whatquality assurance programs will be put into place; ALL	

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	(7) preparation of floors and building for evacuation for the facility's five floors. Based on interview at the time of observation, the Corporate Property Manager, Corporate Engineer, and Building Manager acknowledged the aforementioned conditions. 3.1-19(b)		POLICY/PROCEDURES LIFESAFETY POLICIES WILL BE APPROVED BY THE SAFETY COMMITTEE ANUALLY.	
K 0051 SS=F Bldg. 03	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 Based on observation and interview, the facility failed to ensure 5 of 7 floors of	K 0051	Please accept the following as the facility's credibleallegation of compliance. This plan of	03/04/2016

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	155131		02/08/2016

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MUNSTER MED-INN	7935 CALUMET AVE MUNSTER, IN 46321

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	manual fire alarm boxes was mounted at the proper height. NFPA 72, The National Fire Alarm Code, 2-8.1 states the operable part of each manual fire alarm box shall be not less the forty two inches and not more than fifty four inches from the floor level. This deficient practice could affect all staff, visitors, and residents. Findings include: Based on observation with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 between 11:08 a.m. and 3:40 p.m., all pull stations on floors one through five were measured at 59.5 inches from floor level. Based on interview at the time of each observation, the Corporate Property Manager, Corporate Engineer, and Building Manager acknowledged the aforementioned conditions. 3.1-19(b)		correction does not constitute anadmission of guilt or liability by the facility and is submitted only inresponse to the regulatory requirement. What corrective actions willbe accomplished for those residents found to have affected by the deficient practice? ALL PULL STATIONS ON FLOORSONE THROUGH FIVE WILL BE REINSTALLED AT THE REQUIRED HEIGHT. How the facility willidentify other resident having the potential to be affected by the samedeficient practice and what corrective action will be taken; A FACILITY WALK THRU WAS COMPLETEDBY THE MAINTENANCE MANAGER TO IDENTIFY ANY OTHER PULL STATION NOT MEETING THEREQUIREMENT. NO OTHER DEFICENCIES NOTED. What measures will be putinto place or what systemic changes will be made to ensure that the deficientpractice does not recur: ONCE ALL PULL STATIONS AREREINSTALLED TO THE REQUIRED HEIGHT THE DEFICENT PRACTICE WILL NOT BE ABLE TOOCCUR. How will the correctiveaction be monitored to ensure the deficient practice will not recur, i.e. whatquality assurance programs will be put into place; THE DEFICIENT PRACTICE WILLNOT OCCUR AS THE NUMBER OF PULL STATTIONS WILL NOT CHANGE.	

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K 0056 SS=C Bldg. 03	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. 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 prohibit sprinklers. 18.3.5, 18.3.5.1.			
	1. Based on observation and interview, the facility failed to ensure 1 of 1 complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, Section 5-1.1 states sprinklers shall be installed throughout the premises. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observation with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 at 3:25 p.m., the Basement East Electrical room did not contain a sprinkler head. Based on interview at the time of observation, the Corporate Property	K 0056	What corrective actions willbe accomplished for those residents found to have affected by the deficient practice? 1.A NEW SPRINKLER HEAD WILL BE INSTALLED IN THE BASEMENT EAST ELECTRICAL ROOM. 2.THE EXISTING SPRINKLER HEAD IN THE BASEMENT EAST HOUSEKEEPING ROOM WILL BE ADJUSTED TO THE REQUIRED HEIGHT. How the facility willidentify other resident having the potential to be affected by the samedeficient practice and what corrective action will be taken; A FACILITY WALK THRU WAS COMPLETED BY MAINTENANCE MANAGER TO IDENTIFY ANY OTHER SPRINKLER HEAD NOTMEETING THE REQUIREMENT. NO OTHER DEFICENCIES IDENTIFIED. What measures will be put into	03/04/2016

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	Manager, Corporate Engineer, and Building Manager acknowledged the lack of sprinkler protection and did not have documentation on the construction rating for the room. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 Basement Housekeeping room sprinkler head was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 5-6.4.1.1 under unobstructed construction, the distance between the sprinkler deflector and the ceiling shall be a minimum of 1 in. (25.4 mm) and a maximum of 12 in. (305 mm). This deficient practice could affect staff only. Findings include: Based on observation with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 at 3:21 p.m., the sprinkler head was mounted 32 inches from the ceiling. Based on interview at the time of observation, the Corporate Property Manager, Corporate Engineer, and Building Manager acknowledged the aforementioned condition and provided		place or what systemic changes will be made to ensure that the deficient practice does not recur: FACILITY VENDOR WILL MONITOR AND REPORT DURING THE REQUIRED SPRINKLER INSPECTION MAKING SURE ALL SPRINKLERS ARE LOCATED INSTALLED PROPERLY. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. whatquality assurance programs will be put into place; MAINTENANCE MANAGER WILL MONITOR THE REQUIRED SPRINKLER REPORT AND PRESENT IT TO THE SAFETY COMMITTEE ANNUALLY.	

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	the measurement. 3.1-19(b)			
K 0062 SS=C Bldg. 03	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems were maintained in proper working order. NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems at 10-2.1., NFPA 25, 10-2.2 requires systems to be examined internally for obstructions where conditions exist that could cause obstructed piping. This deficient practice affects all occupants. Findings include: Based on record review with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 at 11:01 a.m., no documentation was available to review an internal 5 year pipe inspection. Based on interview at the	K 0062	Please accept the following as the facility's credibleallegation of compliance. This plan of correction does not constitute anadmission of guilt or liability by the facility and is submitted only inresponse to the regulatory requirement. What corrective actions willbe accomplished for those residents found to have affected by the deficient practice? 1. THE FIVE YEAR PIPEINSPECTION WAS COMPLETED AS REQUIRED (SEE ATTACHED REPORT) 2. THE MISSING ESCUTCHEON INTHE FOURTH FLOOR MEDICATION ROOM WAS INSTALLED. How the facility willidentify other resident having the potential to be affected by the samedeficient practice and what corrective action will be taken; A FACILITY WALK THRU WASCOMPLETED BY THE MAINTENANCE MANAGER TO IDENTIFY ANY OTHER SPRINKLER HEAD NOTMEETING THE	02/22/2016

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	time of record review, the Corporate Property Manager, Corporate Engineer, and Building Manager acknowledged the aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads in 4th floor Medication room was maintained. This deficient practice could affect staff only. Findings include: Based on observation with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 at 12:18 p.m., the fourth floor Medication room was missing one escutcheon. Based on interview at the time of observation, the Corporate Property Manager, Corporate Engineer, and Building Manager acknowledged the missing escutcheon. 3.1-19(b)		REQUIREMENT. NO OTHER DEFICENCIES IDENTIFIED. What measures will be putinto place or what systemic changes will be made to ensure that the deficientpractice does not recur: THE MAINTENANCEMANAGER/DESIGNEE WILL MONITOR DURING THEPREVENTIVE MAINTENANCE ROUNDS. How will the correctiveaction be monitored to ensure the deficient practice will not recur, i.e. whatquality assurance programs will be put into place; THE FINDING WILL BE PRESENTTO THE SAFETY COMMITTEE BY THE MAINTENANCE MANAGER ON A QUARTERLY BASIS.	
K 0064 SS=E Bldg. 03	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 Based on observation and interview, the	K 0064	Please accept the following as the facility's credibleallegation of	02/22/2016

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	facility failed to ensure 4 of 7 floors with portable fire extinguishers were installed correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect all staff, visitors, and residents on the second, third, fourth, and fifth floor. Findings include: Based on observation with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 between 11:08 a.m. and 3:40 p.m., the fire extinguishers on the second, third, fourth, and fifth floor measured 64 inches from the top of the extinguisher to the floor. Based on interview at the time of each observation, the Corporate Property Manager, Corporate Engineer, and Building Manager acknowledged each aforementioned condition. 3.1-19(b)		compliance. This plan of correction does not constitute anadmission of guilt or liability by the facility and is submitted only inresponse to the regulatory requirement. What corrective actions willbe accomplished for those residents found to have affected by the deficient practice? THE DEFICIENT FIREEXTINQUISHERS LOCATED ON THE SECOND, THIRD, FOURTH, FIFTH FLOORS HAVE BEENREINSTALLED TO THE REQUIRED HEIGHTH BETWEEN 42 AND 60 INCHES ABOVE THE FLOOR. How the facility willidentify other resident having the potential to be affected by the samedeficient practice and what corrective action will be taken; THE MAINTENANCE STAFF WILLBE INSERVICED ON INCLUDING THE REQUIRED HEIGHT OF THE EXTINGUISHER AS PART OFTHE MONTHLY FIRE EXTINGUISHER INSPECTION. What measures will be putinto place or what systemic changes will be made to ensure that the deficientpractice does not recur: FIRE EXTINGUISHERS WILL BEMONITORED FOR PROPER HEIGHT REQUIREMENTS DURING THE REQUIRED MONTHLYINSPECTION. How will the correctiveaction be monitored to ensure the deficient	

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			practice will not recur, i.e. whatquality assurance programs will be put into place; THE MAINTENANCEMANAGER/DESIGNEE WILL AUDIT THE FIRE EXTINQUISHER INSPECTION TAGS AND REPORTFINDINGS TO THE SAFETY COMMITTEE FOR THREE MONTHS.	
K 0074 SS=E Bldg. 03	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 o Newly introduced upholstered furniture and mattresses means purchased since March, 2003. Based on observation and interview, the	K 0074	Please accept the following as	02/22/2016

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	facility failed to ensure 2 of 2 curtains in the Theater was flame retardant. This deficient practice could affect staff and up to 10 residents. Findings include: Based on observations with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 between 11:08 a.m. and 3:40 p.m., the curtains in the Theater lacked attached documentation that they were inherently flame retardant. Based on interview at the time of observation, the Corporate Property Manager, Corporate Engineer, and Building Manager confirmed there was no documentation regarding flame retardancy for the curtains and acknowledged the aforementioned condition. 3.1-19(b)		the facility's credibleallegation of compliance. This plan of correction does not constitute anadmission of guilt or liability by the facility and is submitted only inresponse to the regulatory requirement. What corrective actions willbe accomplished for those residents found to have affected by the deficient practice? THE CURTAINS IN THE MOVIETHEATER HAVE BEEN REMOVED. How the facility will identifyother resident having the potential to be affected by the same deficientpractice and what corrective action will be taken; THE FACILITY WILL VERIFY THEPRESENCE OF NECESSARY FLAME SPREAD RATING INFORMATION FOR WINDOW TREATMENTS. INTHE EVENT A LIKE CIRCUMSTANCE IS IDENTIFIED, APPROPRIATE STEPS WILL BE TAKEN TOOBTAIN THE REQUIRED FLAME SPREAD DOCUMENTATION OR REMOVE THE DEFICIENTMATERIAL. What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur: STAFF THAT IS RESPONSIBLE FORFACILITY DÉCOR WILL BE INSERVICED ON THE REQUIREMENT TO OBTAIN	

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			AND FILE FLAMESPREAD RATING DOCUMENTATION. How will the corrective actionbe monitored to ensure the deficient practice will not recur, i.e. what qualityassurance programs will be put into place; THE ADMINISTRATOR OR DESIGNEEWILL PROVIDE A QUARTERLY REPORT FOR THE SAFETY COMMITTEE OF ANY DÉCOR CHANGESTO HAVE THE REQUIRED FLAME SPREAD RATINGS.	
K 0076 SS=D Bldg. 03	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 Based on observation and interview, the facility failed to ensure 2 of 4 cylinders in both the 300 Hall oxygen room and Therapy oxygen room of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires	K 0076	What corrective actions willbe accomplished for those residents found to have affected by the deficient practice? 1. THE TWO UNSUPPORTEDOXYGEN CYLINDERS LOCATED IN THE 300 HALL OXYGEN ROOM WERE IMMEDIATELY SECURED. 2. THE TWO UNSUPPORTEDOXYGEN	02/22/2016

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	freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only. Findings include: Based on observation with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 at 12:45 p.m. then again at 1:51 p.m., two oxygen cylinders were unsupported in the 300 Hall oxygen room. Then again, two oxygen cylinders were unsupported in the Therapy oxygen room. Based on interview at the time of each observation, the Corporate Property Manager, Corporate Engineer, and Building Manager acknowledged each aforementioned condition. 3.1-19(b)		CYLINDERS LOCATED IN THE THERAPY OXYGEN ROOM WERE IMMEDIATELY SECURED. How the facility willidentify other resident having the potential to be affected by the samedeficient practice and what corrective action will be taken; A FACILITY WALK THRU WASCOMPLETED BY MAINTENANCE MANAGER TO IDENTIFY ANY OTHER OXYGEN CYLINDERS NOTMEETING THE REQUIREMENT. NO OTHER DEFICENCIES IDENTIFIED. What measures will be putinto place or what systemic changes will be made to ensure that the deficientpractice does not recur: NURSING AND THERAPY STAFFHAVE BEEN INSERVICED ON HOW TO SECURE OXYGEN CYLINDERS AS REQUIRED. THEMAINTENANCE MANAGER/DESIGNEE WILL MONITOR DURINGTHE PREVENTIVE MAINTENANCE ROUNDS. How will the correctiveaction be monitored to ensure the deficient practice will not recur, i.e. whatquality assurance programs will be put into place; THE MAINTENANCEMANAGER/DESIGNEE WILL AUDIT THE OXYGEN STORAGE LOCATIONS WEEKLY AND REPORTFINDINGS TO THE	

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			SAFETY COMMITTEE FOR THREE MONTHS.	
K 0130 SS=E Bldg. 03	NFPA 101 MISCELLANEOUS Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.THER LSC DEFICIENCY NOT ON 2786 1. Based on record review and interview, the facility failed to ensure a battery replacement program was provided to ensure 114 of 114 single station smoke detectors would operate. This deficient practice affects staff, visitors, and all residents. Findings include: Based on record review with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 at 10:33 a.m., the battery operated smoke detector testing form did not have documentation indicating a battery replacement program. Based on interview at the time of record review, the Corporate Property Manager, Corporate Engineer, and Building Manager acknowledged the aforementioned condition.	K 0130	What corrective actions willbe accomplished for those residents found to have affected by the deficient practice? 1.APREVENTIVE MAINTENANACE PLAN FOR THE BATTERY REPLACEMENT SCHEDULE HAS BEENINSTITUTED. (SEE ATTACHED) 2.THEPENETRATIONS IDENTIFIED IN THE THERAPY FIRE BARRIER WERE FILLED WITH ANAPPROVED 3M FIRE PROTECTION SYSTEM (SEE ATTACHED). How the facility willidentify other resident having the potential to be affected by the samedeficient practice and what corrective action will be taken; 1.) THE BATTERYS HAVE BEENREPLACED IN ALL 114 SINGLE STATION SMOKE DETECTORS. 2.) A FACILITY WALK THRU WASCOMPLETED BY THE MAINTENANCE MANAGER TO IDENTIFY ANY	02/22/2016

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NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321	

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 fire barrier wall 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 tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (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: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.		OTHER PENETRATIONS NOT MEETINGTHE REQUIREMENT. NO OTHER DEFICENCIES IDENTIFIED. What measures will be putinto place or what systemic changes will be made to ensure that the deficientpractice does not recur: 1.THEINSTITUTED SMOKE DETECTOR BATTERY REPLACEMENT SCHEDULE WILL BE PART OF THEPREVENTIVE MAINTENANCE PROGRAM. 2.MAINTENANCESTAFF AND FACILITY CONTRACTORS WILL BE INSERVICED ON HOW TO FILL ALL PENETRATIONS AS REQUIRED. How will the correctiveaction be monitored to ensure the deficient practice will not recur, i.e. whatquality assurance programs will be put into place; 1.THEMAINTENANCE MANAGER WILL AUDIT THE BATTERY REPLACEMENT SCHEDULE AND REPORT THEFINDINGS TO THE SAFETY COMMITTEE FOR 2 QUARTERS. 2.THEMAINTENANCE MANAGER/DESIGNEE WILL AUDIT ANY CONTRACTOR OR INTERNALLY REQUIRED WORKFOR COMPLIANCE AND REPORT FINDINGS TO THE SAFETY COMMITTEE FOR THREE MONTHS.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING	X3) DATE SURVEY COMPLETED 02/08/2016

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	b. It shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect at least 10 residents. Findings include: Based on an observation with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 at 1:48 p.m., the Therapy fire barrier had a half inch gap around wires and a two inch by three inch gap around conduit. Based on interview at the time of each observation, the Corporate Property Manager, Corporate Engineer, and Building Manager acknowledged each aforementioned condition and provided the measurements. 3.1-19(b)			
K 0144 SS=C Bldg. 03	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which	K 0144	What corrective actions willbe accomplished for those residents found to have affected by the deficient practice? THE MAINTENANCE MANAGERADDED AN “ENGINE COOL DOWN PERIOD AFTER	02/22/2016

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	refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's Emergency Generator monthly testing log with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 at 10:44 a.m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Corporate Property Manager, Corporate Engineer, and Building Manager acknowledged the		LOAD TEST" LINE TO THE GENERATOR INSPECTIONCHECKLIST. What measures will be putinto place or what systemic changes will be made to ensure that the deficientpractice does not recur: THE MAINTENANCE MANAGER WILLREVIEW THE GENERATOR INSPECTION CHECKLIST TO ENSURE THAT THE COOL DOWN PERIODIS DOCUMENTATED. How will the corrective action bemonitored to ensure the deficient practice will not recur, i.e. what qualityassurance programs will be put into place; THE MAINTENANCE MANAGER WILL REPORTANY GENERATOR ISSUES TO THE SAFETY COMMITTEE.	

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	aforementioned condition. 3.1-19(b)			
K 0147 SS=E Bldg. 03	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 Based on observation and interview, the facility failed to ensure 5 of 5 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and at least 20 residents. Findings include: Based on observation with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 at 11:57 am. then again at 2:54 p.m., a surge protector was powering another surge protector powering the facility's cable in the Penthouse. Then again a surge protector was powering another surge protector powering fish tank equipment. Also, an extension cord was powering fish tank equipment. Based on interview	K 0147	What corrective actions willbe accomplished for those residents found to have affected by the deficient practice? THE SURGE PROTECTORS ANDEXTENSION CORDS WERE REMOVED FROM THE FISH TANK AND THE CABLE TV CONTROLLER. How the facility willidentify other resident having the potential to be affected by the samedeficient practice and what corrective action will be taken; ALL OTHER POTENTIAL AREASWERE INSPECTED FOR THE IDENTIFIED DEFICIENCIES BY THE MAINTENANCE MANAGER. NODEFICIENCIES IDENTIFIED. What measures will be putinto place or what systemic changes will be made to ensure that the deficientpractice does not recur: THE MAINTENANCE MANAGER WILLAPPROVE THE USE OF ANY ELECTRICAL PROTECTOR OR CORD AND INSURE IT MEETS THELIFE SAFETY REQUIREMENTS. How will the correctiveaction be monitored to ensure the deficient practice will not recur, i.e.	02/22/2016

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	at the time of each observation with the Corporate Property Manager, Corporate Engineer, and Building Manager, acknowledged each aforementioned condition. 3.1-19(b)		whatquality assurance programs will be put into place; THE MAINTENANCEMANAGER WILL CONDUCT MONTHLY AUDITS TO ENSURE NO DEVICES ARE IN USE THAT DO NOTMEET THE REQUIREMENTS. THE AUDITS WILL BE PRESENTED TO THE SAFETY COMMITTEE FOR3 MONTHS	
K 0160 SS=D Bldg. 03	NFPA 101 LIFE SAFETY CODE STANDARD Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Fire Fighter's Service Requirements. 9.4.2, 9.4.3, 18.5.3 (Includes firefighters service phase I key recall and smoke detector automatic recall, firefighters service phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) Based on observation and interview; the facility failed to ensure 1 of 1 elevator equipment rooms was provided with an electrical shunt trip when provided with sprinkler coverage. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a	K 0160	What corrective actions willbe accomplished for those residents found to have affected by the deficient practice? THE REQUIRED SHUNT TRIP WILLBE INSTALLED IN THE ELEVATOR MACHINE ROOM. How the facility willidentify other resident having the potential to be affected by the samedeficient practice and what corrective action will be taken;	02/22/2016

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	means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice would affect staff only. Findings include: Based on observation with the Corporate Property Manager, Corporate Engineer, and Building Manager on 02/08/16 at 3:29 p.m., the elevator equipment room contained 1 sprinkler head and a smoke detector. Based on interview at the time of observation, the Corporate Property Manager, Corporate Engineer, and Building Manager was unable to confirm the elevator equipment was provided with an elevator shunt trip. 3.1-19(b)		A FACILITY WALK THRU WASCOMPLETED BY MAINTENANCE MANAGER TO IDENTIFY ANY OTHER AREA NOT MEETING THEREQUIREMENT. NO OTHER DEFICENCIES IDENTIFIED. What measures will be putinto place or what systemic changes will be made to ensure that the deficientpractice does not recur: THERE ARE NO OTHER AREASTHAT THIS DEFICENCY CAN EXIST.	