STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	(X3) DATE SURVEY COMPLETED
	155636	A. BUILDING 01 / B. WING	09/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON TERRACE	1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219

(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. 01	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: 09/19/16 Facility Number: 000241 Provider Number: 155636 AIM Number: 100291310 At this Life Safety Code survey, Harrison Terrace 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. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has	K 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after October, 19 2016.**	

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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	a capacity of 110 and had a census of 104 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered. Quality Review completed on 09/23/16 - DA			
K 0018 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 Based on observation and interview, the facility failed to ensure that 3 of 12 staff office corridor doors were constructed to resist the passage of smoke. This	K 0018	**K018 DANEPA 101 LIFE SAFETY CODE STANDARD**	09/20/2016

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	deficient practice could affect any of the residents in or near these areas, as well as staff and visitors. Findings include: Based on observation on 09/19/16 between 10:00 a.m. and 2:00 p.m., during a tour of the facility with Maintenance Supervisor, the following doors all had a one quarter inch diameter hole above the handle which would not prevent the passage of smoke in the event of a fire: a) Staff Development office corridor door. b) Environmental Supply office corridor door. c) Guest Relations corridor doors. All the aforementioned doors were acknowledged by Maintenance Supervisor at the time of the observations. 3.1-19(b)		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The corrective action for the holes in the staff development office corridor door, the environmental supply office corridor door, the guest relations corridor doors were filled with fire caulk. This was completed on 9/20/2016 **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;** All residents have the potential to be affected by this deficiency practice; a audits of all doors will be performed to ensure the integrity of the doors remains according to code. **What measures will be put into place or what systemic**	

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			changes will be made to ensure that the deficient practice does not recur; CQI tool will be generated for weekly auditing; this tool will be used and monitored by the head of maintenance and /or designee. Any audit showing less than 100% will then be addressed immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** A CQI tool will be put in place to ensure the deficient practice will not recur, this tool will be monitored weekly, and on an ongoing. All weekly audits will then be presented to the quality assurance committee to verify the weekly audits are not below 100%. This is ongoing. - **By what date the systemic changes will be completed.**	

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			9/28/16	
K 0025 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half 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 and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect up to 2 employees. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 10:00 a.m. to 2:00 p.m. on 09/19/16, there	K 0025	**K025 LIFE SAFETY CODE STANDARD** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The seal that was once in place to cover the old exposed pipe has been resealed and covered on 9/26/2016 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	09/26/2016

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	were exposed pipe penetrations through the ceiling smoke barrier of the service hall mechanical room. These openings were sealed at one time, but it looked as if the product used to seal the original penetrations had dried up and fallen out. The Maintenance Supervisor acknowledged the penetrations at the time of the observation. 3.1-19(b)		**action(s) will be taken;** All residents have the potential to be affected by this deficiency practice; audits of this area will be performed to ensure seal remains intact. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** CQI tool will be generated for weekly auditing; this tool will be used and monitored by the head of maintenance and /or designee. Any audit showing less than 100% will then be addressed immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** A CQI tool will be put in place to ensure the deficient practice will not recur, this tool will be	

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			monitored weekly, and on an ongoing. All weekly audits will then be presented to the quality assurance committee to verify the weekly audits are not below 100%. This is ongoing. **By what date the systemic changes will be completed.** 9/28/2016	
K 0027 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 9 of 9 sets of smoke barrier doors were provided with a legible fire resistance rating label. LSC 4.6.12.1 states whenever or wherever any device, equipment, system, condition arrangement, level of protection, or any other feature is required for compliance with this Code, such device, equipment,	K 0027	**K027 NFPA LIFE SAFEETY CODE STANDARD** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.**	09/20/2016

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	system, condition, arrangement, level of protection, or any other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements. NFPA 80, standards for Fire Doors and Fire Windows at 1-5.1 states listed items shall be identified by a label. Labels shall be applied in locations that are readily visible and convenient for identification by the authority having jurisdiction. This deficient practice could affect all residents within the facility. Findings include: Based on observations on 09/19/16 during a tour of the facility from 10:00 a.m. to 2:00 p.m. with the Maintenance Supervisor, all of the smoke barrier doors in the facility had a fire rating label covered with paint. This was verified by the Maintenance Supervisor at the time of observations. 3.1-19(b)		The paint that was covering the labels on all smoke barriers doors have been removed on 9/21/2016, **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;** All residents have the potential to be affected by this deficiency practice; audits of this area will be performed to ensure that paint on doors are not covering the labels on doors. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** CQI tool will be generated for weekly auditing; this tool will be used and monitored by the head of maintenance and /or designee. Any audit showing less than 100% will then be addressed immediately.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and A CQI tool will be put in place to ensure the deficient practice will not recur, this tool will be monitored weekly, and on an ongoing. All weekly audits will then be presented to the quality assurance committee to verify the weekly audits are not below 100%. This is ongoing. **By what date the systemic changes will be completed.** 9/28/16	
K 0029 SS=E Bldg. 01	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 extinguishing system option is used, the			

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	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			
	Based on observation and interview, the facility failed to ensure 5 of 12 hazardous area corridor doors self-closed and latched into the frames. This deficient practices could affect approximately 12 residents on Brickyard hall and 11 residents on Meridian hall, as well as staff and visitors. Findings include: Based on observation on 09/19/16 between 10:00 a.m. and 2:00 p.m. with the Maintenance Supervisor, the following was noted: a) the Medical Records door lacked a self-closing device. b) the Meridian hall nurses station storage room door lacked a self-closing device. c) the Brickyard hall linen room door lacked a self-closing device. Based on observation on 09/19/16 between 10:00 a.m. and 2:00 p.m. with the Maintenance Supervisor, the following was also noted: d) the Laundry room soiled entrance door had a self-closing device, but failed to latch into the frame.	K 0029	**K029 SFPA 101 LIFE SAFETY CODE STANDARD** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Door closing mechanisms have been installed on the Medical Record door, Meridian Hall, and Brickyard Hall linen room door. Both the laundry room soiled entrance door and the kitchen door have been fixed to latched into frame on 9/20/2016 **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;** All residents have the potential to be affected by this deficiency	09/20/2016

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	e) Kitchen door #2 had a self-closing device, but failed to latch into the frame. All above mentioned doors were acknowledged by the Maintenance Supervisor as being deficient at the time of the observations. 3.1-19(b)		practice; audits of this area will be performed to ensure that door closer are affixed and working properly **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** CQI tool will be generated for weekly auditing; this tool will be used and monitored by the head of maintenance and /or designee. Any audit showing less than 100% will then be addressed immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** A CQI tool will be put in place to ensure the deficient practice will not recur, this tool will be monitored weekly, and on an ongoing. All weekly audits will then be presented to the quality assurance committee to verify the weekly audits are not below	

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			100%. This is ongoing. **By what date the systemic changes will be completed.** 9/28/16	
K 0038 SS=B Bldg. 01	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 Based on observation and interview, the facility failed to ensure 1 of 2 doors to the Kitchen was provided with door latches readily operated under all lighting conditions. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one which is familiar to the average person. For example, a two-step release, such as a knob and independent dead bolt, is not acceptable. In most occupancies, it is important a single action unlatch the door. This deficient practice could affect up to 4 staff working in the Kitchen. Findings include:	K 0038	**K038 NFPA EXIT ACCESS IS ARRABNED SO THAT EXISTS ARE READLY ACCESSIBLE AT ALL TIMES** - **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The two locking mechanism has been removed and one independent lock has been applied to the kitchen door on 9/20/2016. - **How other residents having the potential to be affected by the**	09/20/2016

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	Based on observation with Maintenance Supervisor on 09/19/16 at 11:40 p.m., the Kitchen door was equipped with an independent dead bolt in addition to the door knob. Based on interview with the Maintenance Supervisor at the time of observation, he acknowledged the Kitchen had an independent dead bolt. 3.1-19(b)		**same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by this deficiency practice; audits of this area will be performed to ensure that the one locking mechanism is in place and working accordingly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** CQI tool will be generated for weekly auditing; this tool will be used and monitored by the head of maintenance and /or designee. Any audit showing less than 100% will then be addressed immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and**	

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			A CQI tool will be put in place to ensure the deficient practice will not recur, this tool will be monitored weekly, and on an ongoing. All weekly audits will then be presented to the quality assurance committee to verify the weekly audits are not below 100%. This is ongoing. **By what date the systemic changes will be completed.** 9/28/16	
K 0062 SS=E Bldg. 01	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 Based on observation and interview, the facility failed to ensure 7 of 316 sprinkler heads in the facility were maintained. This deficient practice could affect up to 26 residents and 6 staff on the Mapleton and Brickyard halls. Findings include: 1) Based on observations on 09/19/16	K 0062	**K062 Sprinkler systems are to maintained reliable operating condition** - **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** -	09/20/2016

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	during a tour of the facility with the maintenance supervisor from 10:00 a.m. to 2:00 p.m., the following sprinklers were not tight fitting to the ceiling leaving the attic and the rest of the facility potentially exposed to smoke. a) Resident room # 64 b) Resident room # 70 c) the corridor outside resident room # 66 d) the Medical Records Storage office e) the Memory Directors office f) the Enhanced Care Specialists office g) Resident room # 11 Based on interview on 09/19/16 during a tour of the facility from 10:00 a.m. to 2:00 p.m., the Maintenance Supervisor acknowledged all the above mentioned loose fitting sprinkler heads. 3.1-19(b) 2) Based on observation and interview, the facility failed to ensure cubicle curtains installed in 3 of 4 spas were in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Because of the lack of mesh on the upper part cubicle curtain, the sprinkler location and coordination may be obstructed and the sprinkler spray onto the fire may be shielded. This deficient practice could affect 2 residents in the Mapleton hall spa, 2 residents in the Brickyard hall spa,		Room numbers 64, 70, 66, medical records storage office, memory director office, enhanced care specialist office and room 11 sprinklers heads have been tighten to the ceiling. New 20inch cubicle curtains have been ordered for all shower rooms including Mapleton, Brickyard, Chatham, and the Meridian shower rooms. **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;** All residents have the potential to be affected by this deficiency practice; audits of this area will be performed to ensure that the proper curtains are used at all times. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** CQI tool will be generated for weekly auditing; this tool will be	

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	155636		09/19/2016

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	and 2 residents in the Chatham hall spa. Findings include: Based on observations on 09/19/16 during a tour of the facility with the Maintenance Supervisor from 10:00 a.m. to 2:00 p.m., the privacy curtains located in the Mapleton, Brickyard, and Chatham spa areas had a mesh area that measured approximately 12 inches from the top of the curtain. The standard for the mesh area on this type of curtain is 18 inches, allowing for full sprinkler coverage to be attained within the spa area. The measurements on all curtains were acknowledged by the Maintenance Supervisor at the times of the observations. 3.1-19(b)		used and monitored by the head of maintenance and /or designee. Any audit showing less than 100% will then be addressed immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** A CQI tool will be put in place to ensure the deficient practice will not recur, this tool will be monitored weekly, and on an ongoing. All weekly audits will then be presented to the quality assurance committee to verify the weekly audits are not below 100%. This is ongoing. **By what date the systemic changes will be completed.** 9/28/16	
K 0064 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed,			

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	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 facility failed to ensure 3 of 25 portable fire extinguisher was readily accessible. NFPA 10, 1-6.3 requires fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from areas. NFPA 10, 1-6.6 requires fire extinguishers shall not be obstructed or obscured from view. This deficient practice affects all staff in the service hall area. Findings include: Based on observation with the Maintenance Supervisor on 09/19/16 at 12:21 p.m., access to the fire extinguisher located in the service hall outside the maintenance office was blocked by a cleaning cart, and both extinguishers in the laundry area were blocked from access by linen carts. The Maintenance Supervisor acknowledged all the blocked fire extinguishers at the time of the observations. 3.1-19(b)	K 0064	**K064 FAILED TO ENSURE FIRE EXTINGUSIHER WAS ACCSEESBAEL.** - **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The fire extinguisher located in the service hall area has been cleared of cleaning carts; staffs have been in-service on how to properly store the cleaning carts off the units. **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;** - All residents have the potential to be affected by this deficiency practice; audits of this area will be performed to ensure that staff members are not storing linen carts on or in front of fire extinguishers.	09/20/2016

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			What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; CQI tool will be generated for weekly auditing; this tool will be used and monitored by the head of maintenance and /or designee. Any audit showing less than 100% will then be addressed immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** A CQI tool will be put in place to ensure the deficient practice will not recur, this tool will be monitored weekly, and on an ongoing. All weekly audits will then be presented to the quality assurance committee to verify the weekly audits are not below 100%. This is ongoing	

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			By what date the systemic changes will be completed. 9/28/16	
K 0072 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use for 1 of 10 emergency exits. This deficient practice could affect 14 Chatham hall residents, as well as staff and visitors. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 10:00 a.m. to 2:00 p.m. on 09/19/16, there were numerous items being stored at the end of the Chatham hallway. These items included: two cleaning carts, clean laundry, a	K 0072	**K072 Means of egress shall be continuously maintained free of all obstructions** - **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** All items that were found stored at the end of the Chatham hallway have been removed and, staff has been in serviced to not store items in hallway.	09/20/2016

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	wheelchair, a 32 gallon trash container, a flat moving cart, and a bed. Based on interview at the time of observation, the maintenance supervisor acknowledged all the aforementioned items and stated that they are often placed in the hall areas for storage and are not moved until a later time. 3.1-19(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;** All residents have the potential to be affected by this deficiency practice; audits of this area will be performed to ensure that staff members are not storing items in hallway. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** CQI tool will be generated for weekly auditing; this tool will be used and monitored by the head of maintenance and /or designee. Any audit showing less than 100% will then be addressed immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and**	

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			A CQI tool will be put in place to ensure the deficient practice will not recur, this tool will be monitored weekly, and on an ongoing. All weekly audits will then be presented to the quality assurance committee to verify the weekly audits are not below 100% this is ongoing. **By what date the systemic changes will be completed.** October 19, 2016	
K 0130 SS=F Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure 1 of 9 sets of smoke barrier doors would close and positively latch into the door frame. LSC 4.6.12.2 which says existing life safety features obvious to the public, if not required by the Code, shall be maintained or removed. This deficient practice could affect up to 12 resident on the Mapleton Hall. Findings include:	K 0130	**K130 101 MISCELLANEOUS** - **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Smoke barrier door 1 of 9 has been repaired; both doors latch onto frame of door located on Mapleton Hall.	09/20/2016

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	Based on observation on 09/19/16 at 10:10 a.m. with the Maintenance Supervisor, the Mapleton Hallway smoke doors which were provided with latching hardware, failed to latch into the frame. This was verified by the Maintenance Supervisor at the time of observation. 3.1-19(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;** All residents have the potential to be affected by this deficiency practice; audits of this area will be performed to ensure that doors continue to latch properly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** CQI tool will be generated for weekly auditing; this tool will be used and monitored by the head of maintenance and /or designee. Any audit showing less than 100% will then be addressed immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance**	

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			program will be put into place; and A CQI tool will be put in place to ensure the deficient practice will not recur, this tool will be monitored weekly, and on an ongoing. All weekly audits will then be presented to the quality assurance committee to verify the weekly audits are not below 100% this is ongoing. **By what date the systemic changes will be completed.** 9/28/16	
K 0147 SS=D Bldg. 01	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 1) Based on observation, the facility failed to ensure 1 of 1 extension cord power strip was not used as a substitute for fixed wiring to provide power to equipment with a high current draw. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with	K 0147	**K147 NFPA 101 LIFE SAFETY CODE STANDARD** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.**	09/19/2016

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	NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 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 would affect approximately 2 staff in the laundry area. Findings include: Based on observation on 09/19/16 during the tour at 12:24 pm. with the Maintenance Supervisor, a refrigerator in the laundry area within the service hall was plugged into a power strip and not directly into a wall outlet. The Maintenance Supervisor did acknowledge and remove the power strip before leaving the laundry area. 3.1-19(b) 2) Based on observation, the facility failed to maintain 1 of 1 electrical receptacle in the Business Office. 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 was not in a resident care area but could affect facility staff.		- The power cord that was being used to power the refrigerators has been removed; staff has been in-serviced on the proper methods for plugging in electrical devices. The electrical receptacle has a new receptacle cover over it that was located in the business office **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;** All residents have the potential to be affected by this deficiency practice; audits of this area will be performed to ensure compliance in this area. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** CQI tool will be generated for weekly auditing; this tool will be used and monitored by the head	

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	Findings include: Based on observation on 09/19/16 during the tour at 12:57 pm., the Maintenance Supervisor acknowledged the open electrical receptacle located in the ceiling of the Business Office. 3.1-19(b)		of maintenance and /or designee. Any audit showing less than 100% will then be addressed immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** A CQI tool will be put in place to ensure the deficient practice will not recur, this tool will be monitored weekly, and on an ongoing. All weekly audits will then be presented to the quality assurance committee to verify the weekly audits are not below 100% this is ongoing. **By what date the systemic changes will be completed.** 9/28/16	