

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/15/2014
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NAME OF PROVIDER OR SUPPLIER  GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Dates: 01/14/14 and 01/15/14</p> <p>Facility Number: 000112 Provider Number: 155205 AIM Number: 100288710</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist, Libby Fruth, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Greencroft Healthcare 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 with a partial basement was determined to be of Type V (111) construction and was fully sprinklered except for the area noted in K-56. The facility has a fire alarm</p>	K010000	F 000 Initial Comments This plan of correction constitutes Greencroft Healthcare's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission of or that a deficiency exists, or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. The facility has a capacity of 196. We respectfully request a desk review of this Plan of Correction.	

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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	<p>system with smoke detection in the corridors except for the Therapy wing and the Gables nursing unit and in all spaces open to the corridors. Hard wired smoke detectors that provide a visual and audible signal at the nurses' station were provided in all resident rooms. The facility has a capacity of 240 and had a census of 182 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered except where noted by K-56. All areas providing facility services were provided with sprinkler coverage except where noted by K-56.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/23/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. 1. Based on observation and interview, the facility failed to ensure 4 of 300 corridor doors were capable of resisting smoke. This deficient practice could affect any resident as well as staff and visitors using the 300 central unit hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Lead II and the Director of Environmental Services on 01/14/14 from 1:00 p.m. to 4:00 p.m., three doors separating the B wing construction areas from the corridor each had a hole through the door that was one inch in diameter and the Central Unit medicine preparation room had two pencil size holes above and below the door handle.</p>	K010018	K018A walk through audit of smoke barrier doors was completed. The doors to the medicine room will be sealed with an approved caulk. The doors separating the construction zone have been removed as a part of the renovation project. All closets in question will have their latching changed. One door leaf will use a slide bolt to lock into the head of frame with the second door leaf having an automatic positive latch that will engage the first door. Door 134 has been adjusted to latch. The Environmental Services Director (ESD) or designee will monitor all existing and newly installed doors for non compliant openings and latching where smoke barrier doors are required weekly. He will submit his findings weekly to the Director of Maintenance and	02/10/2014			

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	<p>Based on interview at the time of observation, the Maintenance Lead II and the Director of Environmental Services acknowledged the holes in the doors would not resist the passage of smoke.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 8 of 8 closets with double corridor doors closed and latched automatically into the door frame. This deficient practice could affect at least 20 residents on the Gables Unit as well as an undetermined number of staff and visitors.</p> <p>Findings includes:</p> <p>Based on observation with the Maintenance Lead II and the Director of Environmental Services on 01/15/14 from 9:00 a.m. to 10:45 a.m., the eight clean linen closets on the Gables unit each had a set of double corridor doors. On each set, each door was equipped with a roller latch at the top of the door. Each door could not latch positively into the door frame. This was acknowledged by the Maintenance Lead II and the Director of Environmental Services at the time of observation.</p>		<p>will complete a work order immediately for any deficiencies noted on audits. Completion of work orders will be monitored weekly by the Director of Maintenance or designee. A compliance report will be submitted to QAPI for review quarterly. Hardware for the closets in Gables was ordered on 2/3/2014. Hardware instillation will be completed within 10 days after hardware arrival at facility.</p>				

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	<p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 196 resident room doors closed and latched into the door frame. This deficient practice had the potential to affect 10 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Lead II and the Director of Environmental Services on 01/14/14 from 1:00 p.m. to 4:00 p.m., the door to resident room 134 did not latch in its frame. Based on interview at the time of observation, the Maintenance Lead II and the Director of Environmental Services acknowledged the door to the aforementioned resident room would not latch in its frame.</p> <p>3.1-19(b)</p>				

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K010021 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 10 of 10 smoke barrier door sets would remain self closing when the fire alarm system is activated until the fire alarm system is returned to normal operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Lead II and the Director of Environmental Services on 01/15/14 at 10:10 a.m., all smoke barrier door sets released initially with the fire alarm system but when the system was placed in silence mode, the doors were opened, and the magnetic hold devices engaged causing the smoke/fire doors to remain</p>	K010021	<p>K021We have changed the operation of the fire panel control sequence. The magnets of the smoke doors are not re-energized until the fire alarm has been reset. The fire panel control system will be monitored during preventative maintenance (PM) and during fire drills by the ESD or designee to make sure smoke doors are not re-energized until the system is reset. Results will be documented and reviewed at QAPI meeting for compliance by the ESD or designee quarterly. Alleged date of compliance 2/10/2014.</p>	02/10/2014			

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K010025 SS=E	<p>open instead of self closing as required. Based on interview at the time of observation, the Maintenance Lead II and the Director of Environmental Services acknowledged the magnets holding the smoke barrier doors open should not have reenergized until the fire alarm had been reset.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure the passage of cable through 6 of 10 smoke barriers was protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the</p>	K010025	K025An audit was completed of smoke barrier areas. Openings will be filled with an approved material to maintain the smoke resistance of the smoke barriers. Any time work is completed in smoke barrier walls, maintenance will inspect for new penetration areas and correct immediately with approved caulk. The	02/10/2014			

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	<p>space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect at least 60 residents as well as staff and visitors if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Lead II and the Director of Environmental Services on 01/14/14 from 1:00 p.m. to 4:00 p.m. and on 01/15/14 from 9:00 a.m. to 10:45 a.m., there were exposed penetrations through the smoke barriers above the ceiling tiles at the following locations that were not firestopped:</p> <ol style="list-style-type: none"> <li>The smoke barrier separating the health center from the independent living unit had three cable penetrations that were not sealed with a one inch gap.</li> <li>The central unit smoke barrier had four conduit penetrations that were not sealed.</li> <li>The south unit, north hall smoke barrier had two wire penetrations that were not sealed with one inch annular space around each wire.</li> <li>The activities hall smoke barrier had</li> </ol>		Director of Maintenance or designee will monitor the completed smoke barrier work for compliance and report findings to QAPI quarterly. A plan of correction (POC) will be put in place as needed. Alleged date of compliance 2/10/2014.		

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K010029 SS=E	<p>a pipe sleeve penetration that was not sealed.</p> <p>e. The north unit, south hall smoke barrier had one wire penetration that was not sealed.</p> <p>Based on interview during the times of observation, the Maintenance Lead II and the Director of Environmental Services acknowledged the unprotected openings through the smoke barriers.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ 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 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 5 of 9 doors serving hazardous areas such as a soiled linen room, a kitchen or areas larger than 50 square feet storing combustible materials closed and latched to prevent</p>	K010029	K029An audit was completed for compliance. Effective areas will have approved latching completed.A. In the kitchen we have added a magnetic hold open controlled by the fire panel. B. We have added door closures	02/10/2014			

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	<p>the passage of smoke. This deficient practice could affect 30 residents as well as an undetermined number of staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Lead II and the Director of Environmental Services on 01/14/14 from 1:00 p.m. to 4:00 p.m., the following was noted:</p> <p>a. The kitchen double set of doors into the service corridor were provided with door closers with a hold open feature and would not self close.</p> <p>b. The housekeeping supply room door lacked a door closer. There were at least twenty five cardboard boxes stored in the room which exceeded fifty square feet in size.</p> <p>c. The central unit bathing/shower room door lacked a latching mechanism. The room had two 32 gallon barrels of soiled linen in the room.</p> <p>d. The south unit, east hall bathing room was provided with a door closer with a hold open feature and would not self close. The room had one 32 gallon barrel and one 10 gallon of soiled linen in the room.</p> <p>e. The south unit, west hall bathing room was provided with a door closer with a hold open feature and would not</p>		<p>without hold open to housekeeping areas. C. We have added a latching mechanism to the bathing room door.D. &amp; E. We have removed the hold open feature from the effected doors.The ESD or designee will complete weekly audits of all doors for proper latching. Non-compliant doors will have a work order completed. The ESD or designee will report findings and compliance to the Director of Maintenance or designee weekly and to QAPI quarterly.Alleged date of compliance 2/10/2014.</p>				

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K010038 SS=F	<p>self close. The room had one 32 gallon barrel and one 10 gallon of soiled linen in the room.</p> <p>Based on interview during the times of observation, the Maintenance Lead II and the Director of Environmental Services acknowledged the issues.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 26 of 26 exit door electromagnetic locks remained unlocked while the fire alarm was activated. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6(a) requires doors with special locking arrangements such as electromagnetic locks to unlock upon actuation of an approved fire alarm system installed in accordance with LSC 9.6. LSC 9.6.1.4 requires a fire alarm system to be installed, tested and maintained in accordance with NFPA 72, the National Fire Alarm Code. NFPA 72, 3-9.7.2 requires that all</p>	K010038	<p>K038We have changed the operation of the fire panel control sequence. The electro magnetic locks on exit doors will remain open until the fire panel is reset. The fire panel control system will be monitored during PM and during fire drills by the ESD or designee to make sure smoke doors are not magnetically locking until the system is reset. Results will be documented and reviewed at QAPI meeting quarterly for compliance by the ESD or designee. The independent dead bolt has been removed from the door in question leaving only the door knob ad the single locking device. The ESD or designee will include door hardware as a part of weekly rounds. Doors not in compliance will have a work order</p>	02/10/2014			

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	<p>emergency exits connected to the fire alarm system unlock upon receipt of any fire alarm signal by the fire alarm system serving the protected premises. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Lead II and the Director of Environmental Services on 01/15/14 the electromagnetic locks on all the exits released and unlocked when the fire alarm was activated at 10:10 a.m., but reenergized when the fire alarm was silenced but not reset. Based on interview at the time of observation, the Maintenance Lead II and the Director of Environmental Services acknowledged the electromagnetic locks on the exit doors should not have relocked when the fire alarm was silenced.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure exit access in 1 of 26 exit doors was arranged to be readily accessible in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC 7.2.1.5.4 requires where a latch or</p>		<p>completed for repair. Quarterly reporting of violations will be made to QAPI by the ESD or designee. A POC will be completed as needed. Alleged date of compliance 2/10/2014.</p>				

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	<p>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 familiar to the average person. Generally, 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 any resident, staff or visitor in the adult day care porch exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Lead II and the Director of Environmental Services on 01/14/14 from 1:00 p.m. to 4:00 p.m., the adult day care porch exit door was provided with a door handle with a thumb turn latch and an independent dead bolt. Based on interview at the time of observation, the Maintenance Lead II and the Director of Environmental Services acknowledged the latching device would require a two step release.</p> <p>3.1-19(b)</p>			

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K010047 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to ensure 2 of 4 exit signs on north unit, west hall were continuously illuminated. This deficient practice had the potential to affect the 15 residents, staff and visitors on the north unit, west hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Lead II and the Director of Environmental Services on 01/15/14 from 9:00 a.m. to 10:45 a.m., the exit signs on both sides of the north unit, west hall smoke barrier were not illuminated. Based on interview at the time of observation, the Director of Environmental Services acknowledged the exit signs were not illuminated.</p> <p>3.1-19(b)</p>	K010047	<p>K047The ESD audited all exit lights for lighted bulbs. The bulbs were replaced in effected exit sign. We reviewed our PM practice for frequency. The ESD or designee will monitor on daily rounds and replace bulbs immediately. Findings will be submitted weekly to the Director of Maintenance or designee and Administrator. Additionally, findings will be reported to QAPI quarterly. Alleged date of compliance 2/10/2014.</p>	02/10/2014			

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K010048 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the use of fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice affects any resident, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's written fire safety plan and policy and procedures regarding extinguishment of fire with the Maintenance Lead II and the Director of Environmental Services on 01/14/14 from 10:15 a.m. to 12:00 p.m., the fire safety plan did not address how to use portable fire extinguishers.</p>	K010048	K048The written fire safety plan has been expanded to include fire extinguishers into routine training. Training sessions will be at hire and annually. The ESD or designee will document and report training sessions to QAPI quarterly. QAPI will evaluate and a written POC as needed. Alleged date of compliance 2/10/2014.	02/10/2014			

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K010052 SS=F	<p>Based on interview at the time of record review, the Director of Environmental Services acknowledged the facility has a procedure for use of portable fire extinguishers but was not incorporated into the written fire safety plan.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure documentation for the testing of 1 of 1 fire alarm system components and devices such as smoke detectors, horn/strobe devices, door holder devices, and fire alarm control equipment was complete. NFPA 72, National Fire Alarm Code, 7-3.2 requires fire alarm system devices such as smoke detectors, fire alarm boxes, horn/strobe devices, door holder devices, and fire alarm control equipment be tested annually. NFPA 72, 7-5.1 says paper or electronic media</p>	K010052	K052We have asked the installing company for the fire alarm to provide a full print out of all components and devices that need annual testing. This list will be used to create a preventative maintenance scheduled for recording location and results of visual and functional tests. Records will be maintained of these annual tests with Life Safety Manual. The ESD will review the documentation quarterly for accuracy and completion and report results at the QAPI meeting. A POC will be identified as needed. Alleged date of compliance 2/10/2014	02/10/2014	

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	<p>shall be permitted. Then in 7-5.2.1 it says records shall be retained until the next test and for 1 year thereafter. 7-5.2.2 says a permanent record of all inspections, testing, and maintenance shall be provided. This deficient practice could affect all residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on interview with the Maintenance Lead II during record review, the fire alarm system was tested during the March 2013 scheduled tasks on 03/20/13 but there were no documented results with an itemized list of the fire alarm system components and devices with the locations and results of the visual and functional tests. This was acknowledged by the Maintenance Lead II at the time of record review.</p> <p>3-1.19(b)</p>			

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 6 combustible exterior canopies which was wider than 4 feet. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding four feet in width. This deficient practice could affect residents, staff and visitors using the north unit TV lounge.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Lead II and the Director of Environmental Services on 01/14/14 from 1:00 p.m. to 4:00 p.m., the canopy of wood construction outside of north unit TV lounge exceeded four feet in</p>	K010056	<p>K056We completed an audit of exterior areas requiring sprinkler based on the size of canopy. We have contacted the company we use for a plan and a quote on installation of complete sprinkler coverage. The ESD or designee will audit new exterior attached structures for required sprinklers and report violations to the Director of Maintenance or designee. Report will be presented to the QAPI quarterly by the ESD for compliance. A POC will be identified as needed. Alleged date of compliance for receiving a quote 2/10/2014 and completion of installation 4/15/2014.</p>	02/10/2014			

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K010070 SS=D	<p>width and was not provided with sprinkler protection. Based on interview at the time of observation, the Maintenance Lead II and the Director of Environmental Services acknowledged the canopy was not provided with sprinkler protection.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to enforce it's space heater policy for the use of 1 of 1 portable space heaters in the facility in accordance with NFPA 101, Section 19.7.8. This deficient practice would not directly affect residents but could affect staff using the service hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Lead II and the Director of Environmental Services on 01/14/14</p>	K010070	<p>K070The ESD audited the building for portable space heaters. The staff person involved was reeducated on the non use of space heaters on 1/25/2014. The space heater was removed from the building. The ESD will monitor the building for space heater use weekly and be responsible for reporting violations to the Administrator as well as remove the heater. A routine walk through audit report will be given at QAPI. POC will be identified should violations be reported. Alleged date of compliance 2/10/2014.</p>	02/10/2014			

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K010072 SS=E	<p>from 1:00 p.m. to 4:00 p.m., a space heater was observed plugged into a power strip in the central supply storage room. Based on interview during record review from 10:15 a.m. to 12:00 p.m. on 01/14/14, the Maintenance Lead II and the Director of Environmental Services acknowledged the facility does not allow the use of space heaters in non sleeping staff and employee areas.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are 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 obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of impediments to full instant use in the case of fire or other emergency for 3 of 26 exits. This deficient practice could affect at least 20 residents as well as staff and visitors.</p> <p>Findings include:</p>	K010072	<p>K072The ESD completed a walk through to identify areas with impediments to emergency exits. A. The Christmas totes were removed from the porch and placed in storage. B. &amp; C. The wheelchair in activities hallway and Gables hallway were placed in storage and/or placed in the user room. The ESD or designee will include daily audits of potentially blocked exits during his daily walk through. Violations will be addressed with the staff</p>	02/10/2014

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	<p>Based on observation with the Maintenance Lead II and the Director of Environmental Services on 01/14/14 from 1:00 p.m. to 4:00 p.m., and on 01/15/14 from 9:00 a.m. to 10:45 a.m., the following was noted:</p> <p>a. The adult day care porch exit had twenty large plastic totes stacked in the exit path from the activities office. Based on interview at the time of observation, the Maintenance Lead II and the Director of Environmental Services acknowledged the exit path from the actives office was blocked.</p> <p>b. Ten folded wheelchairs were stored in the hallway outside the activity office. Based on interview at the time of observation, the Maintenance Lead II and the Director of Environmental Services did not know why the wheelchairs were being stored in the hallway.</p> <p>c. Ten folded wheelchairs were stored in the hallway at the north Gables exit. Based on interview at the time of observation, the Maintenance Lead II and the Director of Environmental Services did not know why the wheelchairs were being stored in the hallway.</p> <p>3.1-19(b)</p>		<p>person over seeing the immediate area affected. A work order will be written to correct the issue. The ESD will report weekly to the Administration via documentation form the violation noted and the remedy identified. Findings will be reported to the QAPI routinely. A POC will be identified when appropriate. Alleged date of compliance 2/10/2014.</p>				

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K010144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 2 generators were in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. This deficient practice could affect all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Lead II and the Director of Environmental Services on 01/14/14 from 1:00 p.m. to 4:00 p.m., and on 01/15/14 from 9:00 a.m. to 10:45 a.m., the following was noted:</p> <p>a. The generator remote annunciator panel for the "kitchen" generator is located in the service corridor outside the kitchen.</p> <p>bb The generator remote annunciator panel for the "Gables" generator is located in the corridor on the Gables unit and not in close proximity of a</p>	K010144	<p>K144We moved one annunciator to the Gables nurses station and the other annunciator will be relocated to 24 hour Information Center for monitoring. We will change the procedure for monthly PM of generator. It will include an observation stop watch test of the transfer time from normal power to emergency power. This will be recorded in the log with other items from the generator test. A summary will be presented to QAPI quarterly for review by the ESD or designee. A POC will be identified when appropriate. Alleged date of compliance 2/10/2014.</p>	02/10/2014			

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	<p>regular work station. Based on interview at the time of observation, the Maintenance Lead II acknowledged the locations of the generator remote annunciator's.</p> <p>3.1-19(b)</p> <p>2) Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generators within 10 seconds of building power loss for 12 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of generator load testing documentation with the Maintenance Lead II during record review from 10:15 a.m. to 12:00 p.m. on</p>				

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K010147 SS=E	<p>01/14/13, load testing documentation for the two generators did not document the emergency power transfer time. Based on interview at the time of record review, the Maintenance Lead II stated the generators operate on timers in the morning and staff is not present to document the emergency power transfer time.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure extension cords including powerstrips and non-fused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect least 20 residents, staff and</p>	K010147	K147The ESD will in-service and reeducate housekeeping and nursing staff on the use of power strips and the non-use of extension cords. An audit of rooms was completed by the ESD and extension cords were removed and inappropriate use of power strips was corrected. The ESD or designee will complete weekly audits of the building for extension cord violation and or power strip use violations. Correction will be completed immediately and documented by the ESD or designee. The ESD or designee will submit audit documentation to the Administration weekly to include	02/10/2014	

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	<p>visitors throughout the facility.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Lead II and the Director of Environmental Services on 01/14/14 from 1:00 p.m. to 4:00 p.m., the following was noted:</p> <ul style="list-style-type: none"> <li>a. There was an orange extension cord plugged into a television in resident room 230.</li> <li>b. A nebulizer was plugged into a power strip in resident room 248.</li> <li>c. An extension cord was plugged into an entertainment center in resident room 243.</li> <li>d. An air conditioner was plugged into a power strip in the south unit nurses office.</li> <li>e. A nebulizer was plugged into a power strip in resident room 203.</li> <li>f. A nebulizer was plugged into a power strip in resident room 123.</li> </ul> <p>Based on interview at the time of observation, the Maintenance Lead II and the Director of Environmental Services acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p>		violation and the POC. The ESD or designee will report violations to QAPI routinely. POC will be implemented as needed. Alleged date of compliance 2/10/2014.				