

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155349	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/05/2012
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NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 RANDALLIA DR FORT WAYNE, IN 46805
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K0000	<p>A Life Safety Code Recertification, State Licensure Survey and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/05/12</p> <p>Facility Number: 000240 Provider Number: 155349 AIM Number: 100274960</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Saint Anne Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. The original building consisting of the three story building and the main entrance/dining room was surveyed with Chapter 19 Existing Health Care Occupancies.</p>	K0000		

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>The nursing home is a fully sprinklered three story building with a basement of Type II (222) construction, the main entrance/dining room is a one story fully sprinklered building of Type V (111) construction and the Rehabilitation unit with a physical therapy gym is a one story fully sprinklered building of Type V (000) construction. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 168 and had a census of 159 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/12/12.</p>			

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	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0025 SS=E	<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>1. 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 the residents in the third floor men's shower room.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 07/05/12 at 12:55 p.m., the third floor men's shower room has a one half inch hole in the ceiling at the side of the sprinkler head. This was acknowledged by the Maintenance Director at the time</p>	K0025	<p>1. The cover plate for the sprinkler head had fallen off and was replaced and attached so it will remain fastened, covering the gap around the head. These excution covers are regularly inspected for compliance. This cover had fallen off since the last inspection.2 a & b. All foam was removed and the voids were filled with fire retardent cement and caulk. Outside contractors who add woring or pipe to these areas will be instructed as to proper sealing of the penetrations.</p>	07/12/2012

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	<p>of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 3 third floor smoke barrier walls and 1 of 3 first floor smoke barrier walls were 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. Penetrations caused by the passage of wire and/or conduit through the smoke barrier wall were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. 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 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</p>			

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	<p>the specific purpose. This deficient practice could affect 2 of 3 first floor smoke compartments and 2 of 3 third floor smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the Maintenance Director on 07/05/12 from 1:55 p.m. to 2:00 p.m., eleven penetrations in the smoke barrier wall above the lay in ceiling near resident room 115 were sealed with expandable foam then covered with fire caulk. Also, eleven penetrations in the smoke barrier wall above the lay in ceiling near resident room 123 were sealed with expandable foam then covered with fire caulk. This was acknowledged by the Maintenance Director at the time of observations.</p> <p>b. Based on observation with the Maintenance Director on 07/05/12 at 2:20 p.m., there was a one inch unsealed penetration along side the ventilation duct in the smoke barrier wall near resident room 302.</p> <p>Measurements were provided by the Maintenance Director at the</p>				

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K0027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 8 sets of basement smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect any number of staff in the basement.</p> <p>Finding include:</p> <p>Based on observation with the Maintenance Director on 07/05/12 at 1:25 p.m., the smoke barrier doors near the medical</p>	K0027	The door had been hit by a cart that moved the rubber gasket, not allowing the doors to fully close together. The doors and gasket were adjusted to allow full closure of the smoke doors.	07/20/2012			

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	<p>supply storage room did not close completely leaving a one fourth inch gap between the doors near the bottom of the doors. Based on an interview with the Maintenance Director at the time of observation, the doors have been hit and the right door is catching on the astragal preventing it from closing completely.</p> <p>3.1-19(b)</p>			

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K0029 SS=E	<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 the 1 of 1 sets of corridor doors and 1 of 1 single doors entering the laundry room, a hazardous area, were provided with a self closing device and latched into the door frame. This deficient practice could affect any number of staff in the basement.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 07/05/12 at 1:45 p.m., the set of corridor doors entering the laundry room lacked self closing devices and failed to latch into the frame. The single door entering the laundry room did have a self closing device but it failed to self</p>	K0029	A self closure devise was added to the outside door and a latch mechanism was added to the inside door to make it latch to the frame.	07/27/2012

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	<p>close and latch into the frame. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>			

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K0033 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>Based on observation and interview, the facility failed to maintain 2 of 2 exit stairways in accordance with LSC 7.7.1 and LSC 7.7.2. LSC 7.7.1 requires exits to discharge to the public way or an exterior exit discharge. LSC 7.7.2 allows no more than 50 percent of exits to discharge into an area on the level of exit discharge. This deficient practice could affect all residents, staff and visitors evacuated from the second and third floors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 07/05/12 at 12:40 p.m., the southwest stair and northeast stair discharged onto the first floor and not directly to the exterior of the building. This was confirmed by the Maintenance Director at the</p>	K0033	This deficiency will be addressed with the FSES survey to be conducted by RTM.	07/27/2012

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K0038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 13 doors in the path of egress equipped with a magnetic locking system remained unlocked with activation of the building fire protective signaling system. LSC 19.2.1 requires every corridor and exit be in compliance with Chapter 7. LSC 7.2.1.6.2.(d) requires actuation of the fire alarm system shall unlock the doors in the direction of egress and the doors shall remain unlocked until the fire alarm system has been manually reset. This deficient practice could affect any residents evacuated through exit door # 5 located on the first floor.</p> <p>Findings include:</p> <p>Based on an observations with the Maintenance Director on 07/05/12 at at 2:45 p.m., exit door # 5 located on the first floor, which was equipped with a magnetic locking system failed to</p>	K0038	Wiring inside the door had loosened and prevented the door from releasing after 15 seconds of pressure and from releasing during the fire alarm. Wiring was repaired by an outside contractor. This door mechanism will be added to a regular PM inspection system to ensure correct operation.	07/12/2012			

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	<p>remain unlocked when the fire alarm system was placed in silence mode. Additionally at 12:42 p.m., exit door # 5 was labeled with signage stating "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" but did not release when pushed more than thirty seconds. The door did release as a code was entered. This was acknowledged by the Maintenance Director at the time of observations.</p> <p>3.1-19(b)</p>			

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K0044 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 first floor fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect any residents near the main lobby hallway and the first floor nurses' station.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 07/05/12 at 2:34 p.m., the first floor south side fire door failed to latch into the frame. Based on an interview with the Maintenance</p>	K0044	The door was out of alignment causing the door to not latch. The door was adjusted to latch as required.	07/12/2012

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	<p>Director at the time of observation, these doors were confirmed to be fire doors.</p> <p>3.1-19(b)</p>			

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K0062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 basement sprinkler gauges was tested every five years. NFPA 25, Section 2-3.2 states gauges shall be replaced every five years or tested every five years by comparison with a calibrated gauge. This deficient practice could affect any occupant receiving sprinkler protection from the basement water inlet pipe.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 07/05/12 at 1:50 p.m., the basement sprinkler gauge lacked a date of calibration or replacement. Based on an interview with the Maintenance Director at the time of observation, this is a water inlet gauge and the only time this area is used is for draining the sprinkler system. He was told by</p>	K0062	These gauges were replaced with new gauges by Shambaugh Fire Prevention.	07/27/2012

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	Shambaugh (sprinkler inspection company) this gauge did not require calibration or replacement. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155349	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/05/2012
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K0067 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure an undetermined number of dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A to protect residents in 4 of 6 smoke compartments on the second and third floors. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects 2 of 3 second floor smoke compartments and 2 of 3 third floor smoke</p>	K0067	The dampers will be inspected and serviced by an outside contractor. A four year PM schedule will be set up to inspect and service these units.	07/27/2012

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	<p>compartments.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 07/05/12 from 2:10 p.m. to 2:12 p.m., there was a smoke barrier damper in the ventilation system above the lay in ceiling at the smoke barrier wall near resident rooms 214 and 323. Based on an interview with the Maintenance Director at the time of observations, he was not aware of the dampers and they have not been inspected in the last seven years.</p> <p>3.1-19(b)</p>				

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K0071 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes:</p> <p>(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5.</p> <p>(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7.</p> <p>(3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4.</p> <p>(4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 laundry chutes was provided with a fire rated door assembly that is self closing. LSC 9.5 requires compliance with LSC 8.2. LSC 8.2.3.2.1(b) requires fire doors shall be self closing. This deficient practice could affect any number of staff in the basement.</p> <p>Findings include:</p>	K0071	The broken door was replaced allowing the two doors to latch and the employees who use this area were instructed on how to close and latch the chute room doors.	07/12/2012

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	<p>Based on observation with the Maintenance Director on 07/05/12 at 1:40 p.m., one of the corridor doors to the basement laundry chute was left open, therefore the laundry chute was open to the corridor. The chute door assembly did not latch into the frame. Based on an interview with the Maintenance Director at the time of observation, the corridor doors were supposed to be closed when not collecting the soiled laundry. The Maintenance Director closed and latched one corridor door into the door frame and released the other to self close and latch into the stationary corridor door. The door did self close but failed to latch into the door frame. At this time the Maintenance Director noticed a problem with the door at the top hinge area and said the facility would have to replace the corridor door in order for it to close properly.</p> <p>3.1-19(b)</p>			

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K0104 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.</p> <p>Based on observation and interview, the facility fail to ensure 3 of 3 third floor duct penetrations were provided with a smoke damper. LSC 101 section 8.3.5.1 states an approved damper designed to resist the passage of smoke shall be provided for each air transfer opening or duct penetration of a required smoke barrier. This deficient practice could affect 3 of 3 third floor smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 07/05/12 from 2:15 p.m. to 2:24 p.m., smoke dampers were not installed on the ventilation duct that penetrated the smoke barrier wall near resident rooms 302 and 314 and the two ventilation ducts that penetrated the smoke barrier wall near resident room 312 on the third floor. This was acknowledged by the Maintenance Director at the time of</p>	K0104	All smoke barriers through the duct work will be inspected and any duct work without dampers will be repaired with new dampers. These dampers will be set up on a four year PM schedule for operation and service inspections.	07/27/2012

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	observation. 3.1-19(b)			

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K0130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment, or system required for compliance with this Code shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any residents in the second floor dining room.</p> <p>Findings include:</p>	K0130	Both doors will be inspected and serviced by an outside contractor. These doors will be set up on an annual service inspection by an outside contractor.	07/16/2012

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	<p>Based on observation with the Maintenance Director on 07/05/12 at 12:50 p.m., there was a rolling fire door protecting the opening from the serving kitchen to the second floor dining room. Based on interview with the Maintenance Director at the time of observation, there has been no inspection since installation.</p> <p>3.1-19(b)</p>			

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K0000	<p>A Life Safety Code Recertification, State Licensure Survey and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/05/12</p> <p>Facility Number: 000240 Provider Number: 155349 AIM Number: 100274960</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Saint Anne Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of NFPA (National Fire Protection Association) 101, LSC (Life Safety Code)and 410 IAC16.2. The Rehabilitation unit and Therapy Gym were surveyed with Chapter 18, New Health Care Occupancies.</p> <p>The nursing home is a fully</p>	K0000			

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	<p>sprinklered three story building with a basement of Type II (222) construction, the main entrance/dining room is a one story fully sprinklered building of Type V (111) construction and the Rehabilitation unit with a physical therapy gym is a one story fully sprinklered building of Type V (000) construction. The facility has a fire alarm system with hard wired smoke detection in the resident rooms, corridors and areas open to the corridors. The facility has a capacity of 168 and had a census of 159 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0039 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes is at least 8 feet. In limited care facilities and psychiatric hospitals, width of aisles or corridors is at least 6 feet. 18.2.3.3, 18.2.3.4</p> <p>Based on observation and interview, the facility failed to ensure the corridor width for 1 of 2 corridors in the Rehabilitation Hall was at least eight feet wide. This deficient practice affects all residents on the Rehabilitation Hall.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 07/05/12 at 12:30 p.m., the corridor width measured six feet from Suite E to Suite O in the Rehabilitation Hall. This was confirmed based on an interview with the Maintenance Director at the time of the observation.</p> <p>3.1-19(b)</p>	K0039	This deficiency will be addressed with an FSES inspection by RTM.	07/27/2012