STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077	

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K010000	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 Dates: 01/22/15 & 01/23/15 Facility Number: 000538 Provider Number: 155620 AIM Number: 100267290 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Zionsville Meadows 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 is a split level facility with each of the two floors exiting at ground level and was determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in	K010000	The creation andsubmission of this plan of correction does not constitute an admission by thisprovider of any conclusion set forth in the statement of deficiencies, or ofany violation of regulation. This provider respectfully requests that the2567 plan of correction be considered as the letter of credible allegation of compliance	

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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	all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 185 and had a census of 152 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 by Dennis Austill, Life Safety Code Specialist on 01/28/15. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010018 SS=E	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 1¾ 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			

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	Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 4 of over 100 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 20 residents, staff and visitors. Findings include: a. Based on observations with the Maintenance Assistant during a tour of the facility from 12:15 p.m. to 3:10 p.m. on 01/22/15, the corridor door to Room 150, the Gift Shop and the Director of Leasing Office each were affixed with a kick down door stop which would enable the door to be propped in the fully open position. b. Based on observation with the Maintenance Assistant during a tour of the facility from 9:20 a.m. to 11:50 a.m. on 01/23/15, the corridor door to the Villa Dining Room was missing the latching plate at the top of the door which provided an impediment to closing and latching. Based on interview at the time of the observations, the Maintenance Assistant stated skilled unit residents have access to the area by the Villa Dining Room and	K010018	Kick down doors stops were removed from the doors ofroom #150, Gift Shop and the Director of Leasing Office. The latching strike plate was reinstalled tothe door for the Villa Dining Room and the door latches correctly. All residents, staff and visitors utilizing theseareas would have the potential to be affected by the alleged deficient practice. An audit of all other facility doors was conductedby the Maintenance Department or designees to ensure no other doors had kickdown door stops and that all required self latching doors were functioningcorrectly. Corrective action was takenas needed. All self latching doors will be checked as part ofthe monthly preventative maintenance program and corrective action and repairswill be conducted as necessary.	02/21/2015

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	acknowledged the aforementioned corridor doors failed to resist the passage of smoke and provided an impediment to closing and latching. 3.1-19(b)			
K010025 SS=E	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 Based on observation and interview, the facility failed to ensure openings through 1 of 19 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. This deficient practice affects 8 residents, staff and visitors in the vicinity of the Cottage 2 Housekeeping Closet. Findings include: Based on observation with the Maintenance Assistant during a tour of the facility from 12:15 p.m. to 3:10 p.m. on 01/22/15, the smoke barrier wall at the Cottage 2 Housekeeping Closet was not	K010025	The eight inch square hole above the entry to theCottage 2 Housekeeping closet was repaired. All residents on Cottage 2 have the potential to beaffected by the alleged deficient practice. Daily rounds of the entire facility will be conductedby management team members paying special attention to the maintenance of smokebarriers. All noted concerns will beplaced in the Maintenance Request Binder and repairs initiated immediately. The Executive Director or Designee will review theMaintenance Request Binder every Friday to ensure that all requested repairshave been	02/21/2015

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	constructed with at least 1/2 hour fire resistance rating because an eight inch square hole in the corridor wall was noted above the entry door to the closet. Based on interview at the time of observation, the Maintenance Assistant acknowledged the aforementioned hole in the smoke barrier wall above the Cottage 2 Housekeeping Closet did not separate the room from the corridor by walls constructed with at least 1/2 hour fire resistance rating. 3.1-19(b)		made.	
K010027 SS=E	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 Based on observation and interview, the facility failed to ensure 1 of 2 sets of Cottage 2 smoke barrier door sets would close to form a smoke resistant barrier. Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors which swing in the same direction and equipped with an astragal to have a coordinator to ensure the door	K010027	The door closing coordinator for the smoke barrierdoors near Cottage 2 nurses' station was repaired and the doors now functioncorrectly. All residents, staff, and visitors on Cottage 2 havethe potential to be affected by the alleged deficient practice. All smoke barrier doors will be checked a minimum ofmonthly by	02/21/2015

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	which must close first always closes first. This deficient practice could affect 28 residents, staff and visitors in vicinity of the smoke barrier doors by the Cottage 2 Nurses Station if smoke was allowed to move from one smoke compartment to another. Findings include: Based on observation with the Maintenance Assistant during a tour of the facility from 12:15 p.m. to 3:10 p.m. on 01/22/15, the set of smoke barrier doors in the corridor by the Cottage 2 Nurses Station swing in the same direction, are equipped with an astragal and a door closing coordinator but the door closing coordinator did not function when the smoke barrier door set was manually closed five times which did not ensure the door equipped with an astragal closes last and forms a smoke resistant barrier. Based on interview at the time of observation, the Maintenance Assistant acknowledged the aforementioned smoke barrier door set did not close completely because the door closing coordinator was not functioning to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier. 3.1-19(b)		the Maintenance Supervisor or designee as part of the facilityPreventative Maintenance Program. Allsmoke barrier doors will also be observed during the monthly fire drills toensure appropriate functioning. Immediate repairs will be made as needed. The Preventative Maintenance Logs will be reviewedat the monthly Quality Assurance meeting and action plans will be developed forany noncompliance.	

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K010029 SS=E	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			
	1. Based on observation and interview, the facility failed to ensure 2 of 20 hazardous areas such as combustible storage rooms greater than 50 square feet in size and trash collection rooms were separated from other areas by self closing doors. Doors to hazardous areas are self closing or close automatically upon activation of the fire alarm system. This deficient practice could affect 36 residents, staff and visitors. Findings include: a. Based on observation with the Maintenance Assistant during a tour of the facility from 12:15 p.m. to 3:10 p.m. on 01/22/15, the Chapel stage area measured 375 square feet and was being utilized as a combustible storage area filled from wall to wall with clothes, mattresses, furniture and cardboard	K010029	All combustible storage was removed from the ChapelStage storage area. A self closingdevice was added to the door of the electrical room near room #307. The penetration in the wall of the payrollstorage room was sealed to ensure proper smoke barrier was maintained. All residents, staff and visitors near these areashave the potential to be affected by the alleged deficient practice. Daily rounds of the entire facility will beconducted by management team members paying special attention to themaintenance of smoke barriers. All noted concerns will be placed in theMaintenance Request Binder and repairs initiated immediately. The Chapel Stage storage area will be checkedweekly by the Housekeeping Supervisor or designee to ensure that no combustibleitems have been	02/21/2015

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	boxes. The entry door to the Chapel stage area was a folding accordion type door which was not self closing. b. Based on observation with the Maintenance Assistant during a tour of the facility from 9:20 a.m. to 11:50 a.m. on 01/23/15, the electrical room by Room 307 contained two 32 gallon biohazard waste containers filled with biohazard waste. The corridor door to the electrical room was not equipped with a self closing device. Based on interview at the time of the observations, the Maintenance Assistant acknowledged the aforementioned hazardous areas were not separated from other spaces by a self closing door. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 20 hazardous areas such as combustible storage rooms greater than 50 square feet in size were separated from other spaces by smoke resistant partitions. This deficient practice could affect eight residents, staff and visitors. Findings include: Based on observation with the Maintenance Assistant during a tour of the facility from 12:15 p.m. to 3:10 p.m.		placed in storage.The Executive Director or Designee will review the MaintenanceRequest Binder every Friday to ensure that all requested repairs have been made.	

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	on 01/22/15, the Cottage 2 Payroll Storage Room which measured greater than 100 square feet and was being used to store cardboard boxes had a four inch by twelve inch hole in the wall for the passage of a two inch in diameter pipe which was not smoke resistant and did not separate this combustible storage room from the adjoining shower area on the other side of the wall. Based on interview at the time of observation, the Maintenance Assistant acknowledged the Cottage 2 Payroll Storage Room was not separated from other spaces by smoke resistant partitions. 3.1-19(b)			
K010034 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 Based on observations and interview, the facility failed to ensure items stored in 1 of 2 interior fire escape stairways would not interfere with egress. LSC 7.2.2.5.3 requires usable space within an exit enclosure, including under stairs, or any open space within the enclosure shall not be used for any other purpose which could interfere with egress. This deficient practice affects 22 residents, visitors and staff using the Cottage 3 stairwell for evacuation.	K010034	All noted items have been removed from the Cottage 3stairwell. All residents, staff and visitors that may utilize thestairwell have the potential to be affected by the alleged deficient practice. The Housekeeping supervisor or designee will checkall stairwells daily to ensure no items have been placed in the stair wells forstorage. Any items found in stairwells or impeding any egresswill be removed immediately.	02/21/2015

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NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077	

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	Findings include: Based on observation with the Maintenance Assistant during a tour of the facility from 12:15 p.m. to 3:10 p.m. on 01/22/15, the Cottage 3 exit stairwell on the first floor was used to store four sets of folding doors, a chest of drawers and a housekeeping cart. In addition, a buffer machine and window panes were being stored in the stairwell on the second floor. Based on interview at the time of the observation, the Maintenance Assistant acknowledged the Cottage 3 exit stairwell was used for storage of miscellaneous items which could interfere with egress. 3.1-19(b)			
K010038 SS=E	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 1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 6 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents	K010038	The delayed egress for the exit door by room #327has been repaired and the door opens correctly. The pad lock has been removed from the Chapel Stage storage area. All residents, staff and visitors utilizing thechapel, and all residents, staff and visitors residing on B-wing have thepotential to be affected by the	02/21/2015

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	155620		01/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

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	in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS This deficient practice could affect 42 residents, staff and visitors.		deficient practice. An audit of storage room doors was conducted toensure that there was no further use of pad locks. All egress doors will be checked weekly forproper functioning as part of the facility's Preventative Maintenance Program. All noted concerns will be addressed and corrected immediately.	

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	Findings include: Based on observation with the Maintenance Assistant during a tour of the facility from 9:20 a.m. to 11:50 a.m. on 01/23/15, the exit door by Room 327 to the exterior of the building is marked as a facility exit, is equipped with a delayed egress lock and is provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device but the exit door failed to open within 15 seconds when the door was pushed with the application of force five separate times. Based on interview at the time of observation, the Maintenance Assistant stated the aforementioned exit is a facility exit, is equipped with a delayed egress lock and the necessary signage but acknowledged the exit door failed to open within 15 seconds when the door was pushed with the application of force five separate times. 3.1-19(b) 2. Based on observation and interview, the facility failed to provide 1 of over 100 doors to be opened readily from the egress side whenever the building is occupied. LSC Section 7.2.1.5 states, locks, if provided, shall not require the use of a key, a tool, or special knowledge			

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	or effort for operation from the egress side. This deficient practice could affect 20 residents, staff and visitors in the Chapel. Findings include: Based on observation with the Maintenance Assistant during a tour of the facility from 12:15 p.m. to 3:10 p.m. on 01/22/15, the accordion door which runs the length of the stage area in the Chapel was locked with a padlock which required a key to unlock the door. Based on interview at the time of observation, the Maintenance Assistant stated the Housekeeping Supervisor has the only key to unlock the stage area door and does not provide the key to other staff when not on the premises. The Maintenance Assistant acknowledged the stage area door in the Chapel cannot be readily opened at all times when the building is occupied. 3-1.19(b)			
K010046 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1. Based on observation and interview, the facility failed to ensure 1 of 2 battery powered emergency lights was	K010046	A new battery was placed in the noted emergencylight on Cottage 2. The light nowfunctions correctly.	02/21/2015

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	maintained in accordance with LSC 7.9. LSC 7.9.2.4 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect 20 residents, staff and visitors. Findings include: Based on observation with the Maintenance Assistant during a tour of the facility from 12:15 p.m. to 3:10 p.m. on 01/22/15, the battery operated emergency light located in the Cottage 2 Lounge failed to illuminate when its respective test button was pressed five times. Based on interview at the time of observation, the Maintenance Assistant acknowledged the aforementioned battery operated emergency light failed to illuminate when its respective test button was pressed five times. 3.1-19(b)		All residents, staff, and visitors residing onCottage 2 have the potential to be affected by the alleged deficient practice. All emergency lighting will be checked monthly bythe Maintenance Supervisor or designee to ensure proper functioning as part ofthe facility's Preventative Maintenance Program. Any noted concerns will be addressed immediately. The Preventative Maintenance logs will be reviewedby the IDT team at the Monthly Quality Assurance meeting. Action plans will be developed for anytrended noncompliance.	
K010050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077	

(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
	on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2			
	1. Based on record review and interview, the facility failed to document fire drills conducted on the third shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Monthly Fire Drill Report" with the Maintenance Assistant during record review from 9:25 a.m. to 11:40 a.m. on 01/22/15, documentation of a fire drill conducted on the third shift in the fourth quarter of 2014 was not available for review. Based on interview at the time of review, the Maintenance Assistant stated no other fire drill documentation was available for review and acknowledged documentation for a fire drill conducted on the third shift in the fourth quarter of 2014 was not available for review. 3.1-19(b) 2. Based on record review and interview, the facility failed to document activation	K010050	A third shiftfire drill was conducted and documented. Education was provided to the Maintenance Supervisorand Clinical Education Coordinator regarding proper documentation of firedrills. Fire drills will be held according to the AmericanSenior Communities set monthly schedule that will ensure that drills are heldevery shift a minimum of once per quarter with the appropriate variation intimes. Fire drilldocumentation will be reviewed by the IDT team at the monthly Quality Assurancemeeting to ensure that drills were held and documented appropriately for theprevious month	02/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077	

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	of the fire alarm system for second shift fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Monthly Fire Drill Report" with the Maintenance Assistant during record review from 9:25 a.m. to 11:40 a.m. on 01/22/15, documentation for the second shift fire drill conducted on 11/02/14 at 8:30 p.m. stated only the date, shift and time the fire drill was conducted and staff who participated in the fire drill but did not include activation of the fire alarm system and transmission of the fire alarm signal. Based on interview at the time of record review, the Maintenance Assistant stated no additional fire drill documentation was available for review and acknowledged the aforementioned second shift fire drill documentation did not include activation			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155620		01/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

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	of the fire alarm system and transmission of the fire alarm signal. 3.1-19(b)			
K010052 SS=F	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 Based on record review, observation and interview; the facility failed to ensure all smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over	K010052	A smoke detector sensitivity test has been completedby a third party contracted vendor. Anynoted concern was corrected. All residents, staff and visitors have the potentialto be affected by the alleged deficient practice. Smoke detector sensitivity documentation will bereviewed annually to ensure that the testing has been completed within the pasttwo years and that the testing is scheduled if need be.	02/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077	

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	the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Smoke Detector Sensitivity Test Report" documentation dated 11/27/12 with the Maintenance Assistant during record review from 9:25 a.m. to 11:40 a.m. on 01/22/15, smoke detector sensitivity testing documentation for the most recent two year period was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077	

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	not available for review. Based on interview at the time of record review, the Maintenance Assistant stated the facility switched fire alarm system testing contractors in November 2014 and acknowledged documentation of smoke detector sensitivity testing in the last two years was not available for review. Based on observations with the Maintenance Assistant during a tour of the facility from 12:15 p.m. to 3:10 p.m. on 01/22/15 and from 9:20 a.m. to 11:50 a.m. on 01/23/15, smoke detectors hard wired to the fire alarm system were observed installed in the corridors and in all resident sleeping rooms. 3.1-19(b)			
K010062 SS=C	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 1. Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 2-4.1.4 requires a supply of at least six spare	K010062	An additional spare side mount sprinkler has beenobtained. Escutcheon plates have beenplaced on the sprinkler heads in the closets of rooms # 215, 217, 219, 307,315, 323, 333. The sprinkler head inRoom #217 has been replaced. The CAT 5cable has been removed from around the sprinkler head in the Memory CareFacilitator Office.	02/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077	

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	sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement. Findings include: Based on observation with the Maintenance Assistant during a tour of the facility from 12:15 p.m. to 3:10 p.m. on 01/22/15 and from 9:20 a.m. to 11:50 a.m. on 01/23/15, a total of one sidewall spare sprinkler was located on the premises in the spare sprinkler cabinet in the sprinkler riser room by the oxygen storage and transfilling room. A total of three spare sprinkler cabinets are located in the facility one of which is in the aforementioned room, one is in the Cottage 2 sprinkler riser room and one is at the sprinkler riser in the boiler room. Sidewall sprinklers were observed installed throughout the corridors in the facility. Based on interview at the time of observation, the Maintenance		All residents residing in the above listed roomshave the potential to be affected by the alleged deficient practice. A full house audit of all sprinkler heads wasconducted to ensure that escutcheon plates are in place and the sprinkler headsare in good repair. Repairs were made asneeded.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077	

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	Assistant acknowledged sidewall sprinklers were installed in the facility and a total of one spare sidewall sprinkler was located in spare sprinkler cabinets on the premises. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 7 of over 100 sprinkler heads were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect 14 residents, staff and visitors. Findings include: Based on observations with the Maintenance Assistant during a tour of the facility from 9:20 a.m. to 11:50 a.m. on 01/23/15, automatic sprinkler locations in the closet for Room 215, 217, 219, 307, 315, 323 and 333 each had a missing escutcheon. Based on interview at the time of the observations, the Maintenance Assistant acknowledged the aforementioned automatic sprinklers each had a missing escutcheon. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077	

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	3. Based on observation and interview, the facility failed to replace 1 of over 100 sprinklers in the facility which had become corroded, had paint, lint or other foreign materials on them. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 2 staff and visitors in Room 217. Findings include: Based on observation with the Maintenance Assistant during a tour of the facility from 9:20 a.m. to 11:50 a.m. on 01/23/15, the automatic sprinkler in the closet for Room 217 was partially covered with white paint. Based on interview at the time of observation, the Maintenance Assistant acknowledged the aforementioned automatic sprinkler was partially covered with white paint. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077	

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	4. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. LSC 9.7.1 states all automatic sprinkler systems shall be maintained in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 states sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect 1 staff and visitors in the Memory Care Office in Cottage 2. Findings include: Based on observation with the Maintenance Assistant during a tour of the facility from 12:15 p.m. to 3:10 p.m. on 01/22/15, a blue cable was wrapped around a two foot length of sprinkler pipe in the Memory Care Office in Cottage 2. Based on interview at the time of observation, the Maintenance Assistant acknowledged the aforementioned sprinkler pipe location was being used to support nonsystem components. 3.1-19(b)			
K010064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155620		01/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

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	health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 2 kitchen area portable fire extinguishers requiring a 12 year hydrostatic test were emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. Fire extinguishers passing the applicable 6-year requirement of 4-4.3 shall have the maintenance information recorded on a suitable metallic label or equally durable material having a minimum size of 2 inches by 3 1/2 inches. The new label shall be affixed to the shell by a heatless process, and any old maintenance labels shall be removed. These labels shall be of the self destructive type when removal from a fire extinguisher is attempted. The label shall include the following information: (a) Month and year the maintenance was performed, indicated by a perforation such as is done by a hand punch. (b) Name or initials of person performing the maintenance and name of agency performing the maintenance. NFPA 10 at Section 4-4.4.2, Verification of Service (Maintenance or Recharging) requires each extinguisher that has undergone maintenance that includes internal examination or has been	K010064	The noted fire extinguisher in the kitchen hadmaintenance completed by a third party contracted vendor. Appropriate labels were placed on the fireextinguisher. All staff that work in the kitchen have thepotential to be affected by the alleged deficient practice. An audit of all fire extinguishers was conducted toensure all appropriate maintenance has been completed and appropriate charge ismaintained. Fire extinguishers will continued to be checkedmonthly and corrective measures taken when appropriate.	02/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077	

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	recharged shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch. This deficient practice could affect 5 staff and visitors in the kitchen. Findings include: Based on observation with the Maintenance Assistant during a tour of the facility from 9:20 a.m. to 11:50 a.m. on 01/23/15, the portable fire extinguisher in the kitchen by the entrance to the Family Dining Room was manufactured in 1999 and had an affixed label and collar stating the most recent documented six year maintenance procedures were performed in February 2008. Based on interview at the time of observation, the Maintenance Assistant acknowledged it had been more than six years since the most recent six year maintenance procedures had been			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077	

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	performed for the aforementioned portable fire extinguisher in the kitchen. 3.1-19(b)			
K010067 SS=F	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 Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) 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 (where applicable) 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 could affect all residents, staff and visitors. Findings include:	K010067	Inspections and maintenance of the facility firedampers were conducted by a third party contracted vendor. All residents, staff and visitors have the potentialto be affected by the alleged deficient practice. Fire damper inspections will be set on a routine 4year inspection schedule. Inspection info will be reviewed annually to ensuretimely inspections have been completed or are scheduled to maintain compliance.	02/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077	

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	Based on review of PDF Mechanical LLC "Room/Hallway Fire Damper Inspection 2009" documentation dated 03/10/09 with the Maintenance Assistant during record review from 9:25 a.m. to 11:40 a.m. on 01/22/15, documentation of fire damper inspection and maintenance performed within the most recent four year period was not available for review. Based on observations with the Maintenance Assistant during a tour of the facility from 9:20 a.m. to 11:50 a.m. on 01/23/15, a fire damper was noted in the ceiling HVAC supply vent in the Library and in the wall above the housekeeping door by the oxygen storage and transfilling room. No documentation was observed affixed to each fire damper indicating the date of the most recent inspection and necessary maintenance. In addition, the facility contacted PDF Mechanical to perform fire damper inspection and maintenance during the surveyor tour of the facility at which time an on site PDF Mechanical technician stated fire dampers were installed at various locations throughout the facility. Based on interview at the time of record review and of the observations, the Maintenance Assistant acknowledged documentation of fire damper inspection and maintenance performed within the most recent four year period was not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077	

(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
	available for review. 3.1-19(b)			
K010074 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 Based on record review, observation and interview; the facility failed to ensure valences and window curtains in 1 of 11 smoke compartments were flame resistant. This deficient practice could affect thirty residents, staff and visitors. Findings include: Based on record review with the Maintenance Assistant from 9:25 a.m. to 11:40 a.m. on 01/22/15, documentation of window curtain flame resistant	K010074	All of the valances in rooms 147-154 and the MovingForward Dining Room have been treated with Fire retardant. Labels have been affixed to the valancesindicating the date and type of retardant used during treatment. All residents residing on Moving Forward Unit havethe potential to be affected by the alleged deficient practice. An audit of all draperies and shower curtainsthroughout the facility was conducted to ensure that all were properly treatedfor flame resistance.	02/21/2015

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(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
	documentation was not available for review. Based on observations with the Maintenance Assistant during a tour of the facility from 12:15 p.m. to 3:10 p.m. on 01/22/15, window curtains installed in Room 147 through 154 and the Moving Forward Dining Room had no affixed documentation stating each curtain was inherently flame retardant. Based on interview at the time of record review and of the observations, the Maintenance Assistant stated window curtains are not treated with a flame retardant material and acknowledged documentation for flame retardant material treatment and window curtain flame resistant documentation was not available for review. 3.1-19(b)		The Housekeeping Supervisor will keep a log of allmaterials that have been manually treated for flame resistance.	
K010144 SS=F	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. 1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 5 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or	K010144	A load test for the emergency generator wasconducted, and calculations completed to ensure 30% of the rated capacity wasmet. An inspection of the startingbatteries was also conducted and documented. All residents have the potential to be affected bythe alleged deficient practice.	02/21/2015

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	loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator-Weekly Exercise/Monthly Load Test Log" documentation with the		The facility maintenance staff was reeducated on theproper inspection of and documentation of emergency generators. The emergency generator will be inspected weekly andmonthly load test conducted and documented per the facility's PreventativeMaintenance Program. PreventativeMaintenance Logs will be reviewed by the IDT team at the monthly QualityAssurance meeting. Action plans will bedeveloped for any trending concerns.	

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	Maintenance Assistant during record review from 9:25 a.m. to 11:40 a.m. on 01/22/15, documentation of monthly load testing for July 2014 through November 2014 was not available for review. Based on interview at the time of record review, the Maintenance Assistant stated no additional monthly load testing documentation was available for review and acknowledged documentation of monthly load testing for July 2014 through November 2014 was not available for review. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 19 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99			

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	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. Findings include: Based on review of "Emergency Generator Preventive-Weekly Inspection Checklist" documentation with the Maintenance Assistant during record review from 9:25 a.m. to 11:40 a.m. on 01/22/15, documentation of weekly inspections of the starting batteries for the emergency generator for the nineteen week period of 08/08/14 through 10/31/14 and 11/24/14 through 01/12/15 was not available for review. Based on interview at the time of record review, the Maintenance Assistant acknowledged documentation of weekly inspections of the starting batteries for the emergency generator for the aforementioned nineteen week period was not available for review. 3.1-19(b)			
K010147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National			

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	Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. 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 42 residents, staff and visitors. Findings include: Based on observations with the Maintenance Assistant during a tour of the facility from 12:15 p.m. to 3:10 p.m. on 01/22/15 and from 9:20 a.m. to 3:10 p.m. on 01/23/15, a refrigerator was plugged into a power strip in the Energy Wellness Center and in the Assistant DON Office by Room 307. Based on interview at the time of the observations, the Maintenance Assistant acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned locations. 3.1-19(b)	K010147	Noted power strips and extension cords have beenremoved from the New Energy Wellness Center and the Assistant Director ofNursing's office. The refrigerators havebeen plugged directly into wall outlets. Staff and residents utilizing these areas have thepotential to be affected by the alleged deficient practice. All staff has been reeducated on the use powerstrips and extension cords. Daily rounds will be conducted and managers willcheck for the use of power strips and extension cords. Any noted usage will be correctedimmediately.	02/21/2015