

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2016
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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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K 0000 Bldg. 01	<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 Date: 08/23/16</p> <p>Facility Number: 000367 Provider Number: 155458 AIM Number: 100289280</p> <p>At this Life Safety Code survey, Highland Nursing and Rehabilitation Center 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 was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors and battery powered smoke detectors in all resident rooms. The facility has the capacity for 38 and</p>	K 0000		
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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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K 0018 SS=E Bldg. 01	<p>had a census of 30 at the time of this survey services are sprinklered</p> <p>All areas with resident access are sprinklered. Three detached storage sheds are unsprinklered.</p> <p>Quality Review completed on 08/25/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Social Services corridor doors did not have an impediment to latching. This deficient</p>	K 0018	K018 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The door	09/14/2016			

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K 0029 SS=F Bldg. 01	<p>practice could affect staff and up to 17 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 08/23/16 at 11:48 a.m., the Maintenance Director acknowledged the corridor door to the Social Services office had a door stop installed on the corridor door.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with</p>		<p>stop has been removed from the Social Services office. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? Any residents who enter the SS office have the potential to be affected. All office doors will be audited for door stops and if present, stops will be removed. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director and other Department Managers who have offices will be educated on door stops not to be used on corridor doors. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? All offices will be audited monthly by Administrator/designee for 6 months to determine if any new installation of door stops. Results presented to QA Committee for any recommendations. 5) When will the systemic changes be completed? By September 14, 2016</p>		

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	<p>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 2 of 2 hazardous cooking areas was separated from the corridor by smoke resistive partitions and/or doors that positively latch into the frame. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>a) Based on observation with the Maintenance Director on 08/23/16 at 11:24 a.m., a mobile popcorn popper was in the Dining Room. The Dining Room is open to the corridor leading to the front entrance. Based on interview at the time of observation, the Maintenance Director acknowledged that vegetable oil is used to cook the popcorn and was being operated in the Dining Room.</p> <p>b) Based on observation with the Maintenance Director of 08/23/16 at 12:11 p.m., the Kitchen corridor door was caught on the trash can when tested. Once the trash can was removed, the door failed to latch into the frame. Based on</p>	K 0029	<p>K029 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a) The popcorn popper will only be operated in the kitchen. b) The door has been adjusted to latch into the frame. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All residents who go to the dining room have the potential to be affected. The Popcorn popper will be taken to the kitchen when popcorn is cooked in it. The door to the kitchen will remain closed and will be properly adjusted to latch into the frame. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? a) A mobile cart will be used to transport the popcorn popper to the kitchen in order to cook the popcorn, then can be wheeled back out to serve the popcorn. The Activity and Dietary</p>	09/14/2016

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K 0046 SS=C Bldg. 01	<p>interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1.</p> <p>Based on record review and interview; the facility failed to provide documentation of 3 out of 12 months of testing. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual</p>	K 0046	<p>staff will be educated to this process. b) The Dietary staff will be educated on keeping the door closed and to move trash can when door is open so as not to impede proper closure of the door. All doors will be assessed for proper closure into the door frames. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Administrator/designee will monitor activity calendar forevents planned to make popcorn to assure properly prepared in kitchen. Results of these audits will be summarized and presented to QA for 6 months for further recommendations. 5) When will the systemic changes be completed? By September 14, 2016</p> <p>K046 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Emergency Lighting Documentation had been destroyed by water when stored in the Boiler Room. Now</p>	09/14/2016

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K 0050 SS=F Bldg. 01	<p>test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 08/23/16 at 11:03 a.m., the battery operated emergency light documentation was only provided for three out of twelve months. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency</p>		<p>relocated documentation Binder to area in Administrator's office. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All residents have potential to be, but no residents were affected. All Maintenance Documents will now be stored in the Administrator's office. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Emergency Lighting will be tested monthly and all Maintenance documents will be stored in a binder secured in the Administrator's office. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Administrator will audit Emergency Lighting and proper location of Maintenance reports and documentation monthly for 6 months and present results to QA monthly. 5) When will the systemic changes be completed? By September 14, 2016</p>		

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	<p>fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>1. Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 3 of the last 4 calendar quarters. This deficient practice could affect all occupants.</p> <p>Findings include: Based on record review of the "Fire Drill Report" forms with the Maintenance Director on 08/23/16 at 10:31 a.m., the documentation for a first shift fire drill for the fourth quarter of 2015 was not available for review. Additionally, the documentation for a second shift fire drill for the first quarter of 2016, third, and fourth quarter of 2015 was not available for review. Additionally, the documentation for a third shift fire drill for the first quarter of 2016, third, and fourth quarter of 2015 was not available for review. Based on interview at the time of record review, the Maintenance</p>	K 0050	<p>K050 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1) Fire Drills will be conducted and documented as required. 2) Fire Drills will include verification of transmission of the fire alarm signal to the monitoring station.</p> <p>2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? This deficient practice has the potential to affect, but has not affected, all residents, staff and visitors. Fire Drills will be conducted so results are properly verified, conducted timely and documentation will be properly maintained.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Staff will be re-educated by Corporate</p>	09/14/2016

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	<p>Director acknowledged the lack of documentation.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to ensure 3 of 5 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on record review of titled "Fire Drill Report" with the Maintenance Director on 08/23/16 at 10:31 a.m., the documentation for the drills failed to include verification of transmission of the fire alarm signal to the monitoring station for three of the five drills conducted. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p>		<p>Regional Maintenance Director on regulations for conducting Fire Drills timely, and proper verification of the transmission of signals and documentation. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Administrator/designee will perform monthly audit of Fire Drill documentation for timeliness and verification of signal to the monitoring station. The results of the audits will be summarized and presented to QA for 6 months for further recommendations. 5) When will the systemic changes be completed? By September 14, 2016</p>				

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K 0052 SS=C Bldg. 01	<p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review and interview on 08/23/16 at 10:46 a.m., the Maintenance Director acknowledged the last fire alarm</p>	K 0052	<p>K052 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Fire Alarm System Annual Inspection for this facility was conducted timely by SafeCare on 12-7-2016 and the report was available on the SafeCare internetsite. The identified report from 4-27-2015 was obtained from the SafeCarereport site which was actually a report for another facility, however the Surveyor and the Maintenance staff reviewed the incorrect document at the time of the survey. The original hard copy document had been destroyed by water while stored in the Boiler Room, so now all maintenance records will be stored in the Administrator office.</p> <p>2) How will other residents having the potential to be affected by the same deficient</p>	09/14/2016			

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K 0053 SS=C Bldg. 01	inspection report from SafeCare was dated 04/27/15. 3.1-19(b) NFPA 101, 483.70(a)(7) LIFE SAFETY CODE STANDARD In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms,		practice be identified and what corrective action(s) will be taken? All residents have the potential to be affected, however no residents were affected. Correct reports will be obtained and provided. All Fire alarm system inspections will be completed timely as required. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Reports will be stored in Administrator office instead of the Boiler Room. Annual inspections will continue to be performed per regulations. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Hard copies will be maintained in the Administrator office rather than downloaded from the SafeCare site. Administrator/designee will audit maintenance manual to assure all inspections have been performed timely and that all appropriate documentation is in place. 5) When will the systemic changes be completed? By September 14, 2016		

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	<p>resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. 42 CFR 483.70(a)(7)</p> <p>Based on record review and interview, the facility failed to provide testing documentation for 18 of 18 single station smoke detectors per manufacturer's recommendation. 410 IAC 16.2 Licensure of Health Facilities Rules at 16.2-3.1-19(ff)(3) requires a health facility licensed under IC 16-28 and this rule to have a battery operated or hard-wired smoke detector in each resident room before July 1, 2012. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 08/23/16 at 10:35 a.m., the "Battery Check Smoke Detectors" indicated the single station smoke detectors were tested monthly. Documentation indicated monthly testing only from 08/13/16 to 02/13/16. Based on observation, resident room 15 smoke detector indicated that the device to be tested weekly. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed no other documentation is available for</p>	K 0053	<p>K053 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Smoke Detector in room 15 will be tested weekly. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All Occupants have the potential to be affected, but no residents have been affected. All Smoke Detectors in the facility that require to be tested weekly will be tested weekly. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All rooms will be audited to determine if the smoke detectors require monthly or weekly testing. Any smoke detectors that require to be tested weekly will be tested weekly and any that need to be tested monthly will be tested monthly. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Results of all Smoke</p>	09/14/2016

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K 0062 SS=C Bldg. 01	<p>review.</p> <p>3.1-19(b)</p> <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 record review and interview, the facility failed to ensure an annual test to check backflow preventers for 1 of 1 sprinkler systems was conducted as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 9-6.2.1 indicates all backflow preventers installed in fire protection system piping shall be tested annually. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 08/23/16 at 10:44 a.m., the last record of backflow testing by SafeCare was dated 04/29/15.</p>	K 0062	<p>Detector testing for each month will be summarized and provided to the QA Committee monthly for 6 months for further recommendations. 5) When will the systemic changes be completed? By September 14, 2016</p> <p>K062 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Backflow system for the fire protection system piping shall be tested by September 14, 2016.</p> <p>2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All occupants have the potential to be affected, but no residents have been affected. The Backflow system shall be tested annually by a qualified professional as required. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Administrator/designees shall</p>	09/14/2016

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K 0070 SS=E Bldg. 01	<p>Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition and confirmed no other documentation was available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 Based on observation, interview, and record review, the facility failed to enforce the policy for the use of 1 of 1 portable space heaters in accordance with NFPA 101, Section 19.7.8. This deficient practice could affect staff and up to 11 residents.</p>	K 0070	<p>perform an audit for all annual maintenance inspections that need to be completed and verify that required inspections are scheduled timely. Any such inspections not scheduled, shall be scheduled in coordination with the company Regional Maintenance Director. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The Administrator/designee will provide summary of audit results to QA monthly for 6 months for further recommendations. 5) When will the systemic changes be completed? By September 14, 2016</p> <p>K070 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Space Heater identified was not in use and was only being stored in that office. It has been removed from the facility premises. 2) How</p>	09/14/2016	

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	<p>Findings include:</p> <p>Based on record review with the Maintenance Director on 08/23/16, the space heater policy states the facility does not allow space heaters. Based on observation at 11:33 a.m., a space heater was discovered in the Business office. Based on interview at the time of observation, the Maintenance Director acknowledged the space heater were a violation of the facility's policy.</p> <p>3.1-19(b)</p>		<p>will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? Staff and some residents have the potential to be effected, but no one was affected. Staff will be educated of the Facility Policy for space heater use. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director and other Staff will be educated on the facility Space Heater policy that does allow Space Heaters to be used by non-sleeping employees in staff and employee areas as long as meet certain requirements outlined in the Policy. An audit of all offices will be completed by Maintenance Director/designee to determine if any other Space Heaters are present. Any space heaters discovered will be assessed for compliance with facility policy and any that are not compliant will be removed from the premises. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The Maintenance Director/designee will perform a monthly audit of all offices to determine if any Space Heaters are being used. The results of</p>		

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K 0072 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1</p> <p>Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 1 of 4 corridors. This deficient practice could affect staff, visitors, and at least 11 residents</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 08/23/16 at 11:41 a.m., a large printer on wheels was stored in the corridor outside resident room 14. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed that the printer is there overnight.</p> <p>3.1-19(b)</p>	K 0072	<p>the audits will be summarized and presented to QA for 6 months for further recommendations. 5) When will the systemic changes be completed? By September 14, 2016</p> <p>K072 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The printer has been relocated. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? This practice could affect staff, visitors and 11 residents, but has not affected anyone. No items that are not being actively used for resident care shall obstruct the corridors. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Any Equipment not used for Resident medical purposes shall be located in offices or relocated to an area</p>	09/14/2016

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K 0074 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13</p> <p>o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2.</p> <p>o Newly introduced mattresses shall meet the char length and heat release criteria</p>		<p>where the hallway is recessed and it will no longer obstruct the corridor. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The corridors will be audited daily 5 days per week by Maintenance Director/designee to assure no obstructions are present. Results of the audits will be summarized and presented monthly to the QA Committee for 6 months for further recommendations. 5) When will the systemic changes be completed? By September 14, 2016</p>		

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	<p>specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3</p> <p>o Newly introduced upholstered furniture and mattresses means purchased since March, 2003.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 window curtains in the Dining Room was flame retardant. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 08/23/16 between 11:20 a.m. and 12:15 p.m., there were window curtains in the Dining Room. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed there was no documentation was available for review.</p> <p>3.1-19(b)</p>	K 0074	<p>K074 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A flame retardant material has been obtained to spray the curtains in the dining room and this will be done by 9-14-2016. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All occupants have the potential to be affected, but no residents have been affected. The curtains will be sprayed with an approved flame retardant spray. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Any new curtains or other cloth window dressings will be purchased already treated or will be treated with proper fire retardant material prior to hanging. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? An audit will be</p>	09/14/2016	

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K 0144 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 4 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. 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</p>	K 0144	<p>performed by Maintenance Director/designee of all windows to determine if all curtains are properly treated with flame retardant material. 5) When will the systemic changes be completed? By September 14, 2016</p> <p>K144 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The documentation for the Generator testing had been destroyed when stored in the Boiler room, so now all Test records will be stored in the Administrator office. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All residents could be affected, not no residents have been affected. All Emergency Generator Testing documentation will be stored in the Administrator office. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not</p>	09/14/2016

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K 0147 SS=F Bldg. 01	<p>maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the generator log "Emergency Generator - Monthly Test Log" with the Maintenance Director on 08/23/16 at 11:00 a.m., there was no documentation of a generator load test for the months of September 2015 through January 2016. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition and was unable to provide any further documentation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1</p> <p>1. Based on observation and interview, the facility failed to ensure 4 of 4 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for</p>	K 0147	<p>recur? All Maintenance reports and documents will be stored in the Administrator office. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The Administrator will audit the Maintenance Records to be sure all required testing records are in place. This will be performed monthly for 6 months and results presented to QA for any further recommendations. 5) When will the systemic changes be completed? By September 14, 2016</p> <p>K147 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1) a) The oxygen concentrator has been plugged directly into a wall outlet. b) One of the surge protectors have been removed from the Social service office. c) The resident in Room 7 is no longer in</p>	09/14/2016			

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	<p>fixed wiring of a structure. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Director on 08/23/16 between 11:28 a.m. to 12:05 p.m. the following was discovered:</p> <p>a) a box light outlet was powering an oxygen concentrator in resident room 17</p> <p>b) a surge protector was powering another surge protector powering computer components in the Social Services office</p> <p>c) a surge protector was powering three separate medical devices in resident room 7. Additionally, a box light outlet was powering an oxygen concentrator.</p> <p>d) a surge protector was powering a refrigerator and a microwave in the MDS office.</p> <p>Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain an electrical outlet in 1 of 1 Soiled Utility room. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts,</p>		<p>facility and all medical electrical equipment has been removed. d) The refrigerator and microwave have been removed from the MDS office. 2) The outlet in the Soiled Utility room has been properly placed and covered. 2) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All occupants had the potential to be affected, but no one has been affected. The Maintenance Director and staff will be educated regarding proper usage of surge protectors and proper power sources for electrical equipment. The Maintenance Director will be educated on proper practices for covering electrical wires. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? An electrician has been scheduled to increase the number of electrical outlets in room 7. An audit of all rooms and offices will be completed by Maintenance/designee to review for proper surge protector usage and power sources for medical devices. Any devices identified will be corrected and/or removed. An in-service to Maintenance Director and staff will be provided to educate on proper electrical cords and medical devices that can and cannot be used in facility</p>				

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	<p>requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff and at least 11 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 08/23/16 at 11:37 a.m., an outlet in the Soiled Utility room was hanging outside of the drywall and not screwed in. A dried piece of duct tape was covering the exposed wiring. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>setting. 4) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The Administrator/designee will perform rounds twice weekly with Maintenance Director to review all electrical connections and to assure compliance. Results will be summarized and presented to QA monthly for 6 months for any further recommendations. 5) When will the systemic changes be completed? By September 14, 2016</p>		