

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155754	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/28/2015
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NAME OF PROVIDER OR SUPPLIER HUBBARD HILL ESTATES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 28070 CR 24 ELKHART, IN 46517
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K 000 Bldg. 02	<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: 04/28/15</p> <p>Facility Number: 001131 Provider Number: 155754 AIM Number: 200823940</p> <p>At this Life Safety Code survey, Hubbard Hill Estates, Inc. 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 facility located on the main level of a two story facility was determined to be of Type V (111) construction and was fully sprinklered except for the lower level elevator machine room. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire</p>	K 000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our allegation of compliance.</p>	
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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 017 SS=E Bldg. 02	<p>alarm system installed in all resident sleeping rooms. The facility has a capacity of 66 and had a census of 57 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the garage which was used for a maintenance shop.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Conference room in the 2100 hall was separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous</p>	K 017	<p>Corrective Action for Residents Affected An electrically monitored smoke alarm will be installed by 5/28/2015 in the Conference Room identified on the 2100 Hall. Other residents having the potential to be affected: No other residents were found to be affected by this alleged deficient practice. Measures to ensure</p>	05/28/2015

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K 025	<p>areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by an automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect 16 residents in the 2100 hall.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Building Services and Maintenance Technician #1 on 04/28/15 at 1:54 p.m., there was a gap between the sliding corridor doors entering the 2100 hall conference room. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because the 2100 hall conference room was not protected by an electrically supervised automatic smoke detection system. Based on an interview at the time of observation, the Director of Building Services acknowledged the gap between the sliding glass doors measured one inch.</p> <p>3.1-19(b) NFPA 101</p>		<p>practice does not reoccur: On 5/15/2015 the Maintenance Department was re-educated on K017 (See Attachment A). The maintenance supervisor or designee will inspect areas weekly as part of our Preventative Maintenance Program.</p> <p>Corrective Action will be monitored by: The results of this monitoring will be brought to the Safety Committee bi-monthly meeting at which time any issues and corrections will be discussed. The results of this review will then be taken to the quarterly QAPI meeting. Monitoring will be on-going.</p>				

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SS=E Bldg. 02	<p>LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect any number of residents throughout the healthcare facility.</p> <p>Findings include:</p> <p>a. Based on an observation with the Director of Building Services and Maintenance Technician #1 on 04/28/15 during a tour of the facility from 12:54 p.m. to 4:31 p.m., five of thirteen attic access panels were a single layer of five eights inch drywall. Based on an interview with Maintenance Technician #1 at the time of observation, he confirmed the ceiling throughout the healthcare facility was constructed of two</p>	K 025	<p>K025 Corrective Action for Residents Affected The five affected attic access panels were repaired by 5/28/2015 to ensure that two layers of 5/8 inch dry wall were in place. The two inch gap around the HVAC line in the ceiling of the Administrator's office closet was sealed by 5/28/2015. Other residents having the potential to be affected: All residents have the potential to be affected, however there was no actual harm to any residents. Measures to ensure practice does not reoccur: On 5/15/2015 the maintenance department was re-educated on K025 (See Attachment) The maintenance supervisor or designee will inspect areas quarterly as part of our Preventative Maintenance Program. Corrective Action will be monitored by: The results of this monitoring will be brought to the Safety Committee bi-monthly meeting at which time any issues will be discussed along with how</p>	05/28/2015	

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K 034 SS=E Bldg. 02	<p>layers of five eights inch drywall.</p> <p>b. Based on observation on 04/28/15 at 1:20 p.m., the Director of Building Services acknowledged there was a two inch unsealed penetration around a HVAC line in the ceiling of the Administrator's office closet.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on observation and interview, the facility failed to ensure items stored in 1 of 4 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 could affect 13 residents in the 2200 hall.</p> <p>Findings include:</p> <p>Based on an observation with Maintenance Technician #1 on 04/28/15 at 2:29 p.m., there were three lawn chairs and two folding chairs stored under of 2200 hall stairway. Maintenance</p>	K 034	<p>they were immediately corrected. The results of this review will then be taken to the quarterly QAPI meeting. Monitoring will be on-going.</p> <p>Corrective Action for Residents Affected The three lawn chairs and two folding chairs that were under 2200 hallway were removed on 4/28/2015. Other residents having the potential to be affected: No other residents were found to be affected by this alleged deficient practice. Measures to ensure practice does not reoccur: On 5/15/2015 the maintenance department was re-educated on K034 (See Attachment) A reminder sign to not store items was placed in these areas. The maintenance supervisor or designee will inspect areas weekly as part of our Preventative Maintenance Program. Corrective Action will be monitored by: The results of this monitoring will be brought to the</p>	04/28/2015

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K 044 SS=F Bldg. 02	<p>Technician #1 acknowledged the 2200 hall stairway was used for storage purposes.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 9 of 9 fire barrier walls were maintained to ensure the fire resistance of the barrier. LSC 7.2.4 refers to 7.2.4.1.1 which refers to 7.1 which refers to 7.1.3.1 which then refers to 8.2.3 which refers to 8.2.3.2.4.2. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the</p>	K 044	<p>Safety Committee bi-monthly meeting at which time any issues and corrections will be discussed. The results of this review will then be taken to the quarterly QAPI meeting. Monitoring will be on-going.</p> <p>K044</p> <p>Corrective Action for Residents Affected</p> <p>By 5/28/2015 the space between the penetrating item and the fire barrier wall was sealed in the 9 fire barrier walls with material that is capable of maintaining the fire barrier.</p> <p>a. The cables area in administrative hall.</p> <p>b. the cable area in .barrier wall near healthcare dining room</p> <p>c. the cable holes in.barrier wall near chapel</p> <p>d. the ½ inch cable space in 2400 hall</p> <p>e. the cable holes in 2300 hall</p> <p>f. the area around the water line in 2200 hall</p> <p>g. the cable hole in 2100 hall</p> <p>h. the space around the electric cable in service hall</p> <p>i. the space around the conduit in rehabilitation hall</p> <p>j. the space around the HVAC vent near main dining room.</p> <p>k. the space near the roof line for sprinkler line near the chapel.</p> <p>Other residents having the potential to be affected:</p>	05/28/2015	

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	<p>sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations and interview on 04/28/15 from 3:05 p.m. to 4: 22 p.m., the Director of Building Services acknowledged the following unsealed penetration either above the ceiling tile or in the attic:</p> <p>a) at the fire barrier wall in the administrative hall there were three penetrations around IT cables measuring one inch each</p> <p>b) at the fire barrier wall near the healthcare dining room there was a penetration measuring two inches around IT cables</p> <p>c) at the fire barrier wall near the chapel there was a penetration measuring one inch around IT cables</p> <p>d) at the 2400 hall fire barrier wall there were three penetration measuring in size</p>		<p>All residents have the potential to be affected, however there was no actual harm to any resident.</p> <p>Measures to ensure practice does not reoccur: On 5/15/2015 the Maintenance Department and IT Department was re-educated on K044 (See Attachment A) The maintenance supervisor or designee will inspect areas each time there has been any new work (cables/pipes etc.) done above the ground floor ceiling. This area will also be checked as part of our quarterly Preventative Maintenance Program.</p> <p>Corrective Action will be monitored by: The results of this monitoring will be brought to the Safety Committee bi-monthly meeting at which time any issues will be discussed and corrections verified. The results of the review will then be taken to the quarterly QAPI meeting. Monitoring will be on-going.</p>	

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K 050 SS=C Bldg. 02	<p>from one half inch around IT cables to one eighth inch around plumbing lines</p> <p>e) at the 2300 hall fire barrier wall there were five penetrations measuring from two by three inches wide to one fourth inch around IT cables</p> <p>F) at the 2200 hall fire barrier wall there was a penetration measuring one inch by six inches around water lines with five additionally penetrations measuring from one fourth inch to three fourths inch</p> <p>g) at the 2100 hall fire barrier wall there was a one inch penetration around IT cables</p> <p>h) at the service hall fire barrier wall there were two penetrations measuring three fourths inch and one half inch around electrical cable and water lines</p> <p>i) at the attic fire barrier wall in the Rehabilitation hall there was a one eighth inch penetration around a conduit</p> <p>j) at the attic fire barrier wall near the main dining room there was a one inch penetration around a HVAC vent</p> <p>k) at the attic fire barrier wall near the chapel there was a two foot section of the adjoining roof was removed to allow the four inch sprinkler line to pass through and into the adjacent smoke compartment</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times</p>			

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	<p>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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Fire Alarm Response Report" forms with the Director of Building Services and Maintenance Technician #1 on 04/28/15 at 12:14 p.m., all first shift fire drills took place between 9:30 a.m. and 10:30 a.m. and all third shift fire drills took place at either 2:30 a.m. or 3:30 a.m. for four of the last four quarters. This was confirmed by the Director of Building Services and Maintenance Technician #1 at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p>	K 050	<p>K050 Corrective Action for Residents Affected It is the practice of this facility to hold fire drills at unexpected times under varying conditions, at least quarterly on each shift. The new Fire Drill schedule was modified by 5/15/2015 to ensure that the drills at different times (2 hours different) each shift. (See Attachment with Fire drill Schedule) Other residents having the potential to be affected: All residents have the potential to be affected, however there was no actual harm to any. Measures to ensure practice does not reoccur: On 5/15/2015 The Maintenance Department was reeducated on K050 (See Attachment) related to definition of varying times. A Fire Drill schedule has been modified to ensure that the drills are at different times each shift. (See Attachment) The maintenance supervisor or designee will review the Fire Drill Log quarterly. Corrective Action will be monitored by: The results of the Fire Drill Log monitoring will be brought to the</p>	05/15/2015	

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K 056 SS=E Bldg. 02	<p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure that a complete automatic sprinkler system was provided for 1 of 1 ambulance entrance canopies in accordance with NFPA 13, Standard for Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13-1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under exterior roofs or combustible canopies exceeding 4 ft. in width. This deficient practice could affect residents evacuated out the ambulance entrance.</p>	K 056	<p>Safety Committee bi-monthly meeting at which time any issues will be discussed and corrected. The results of this review will then be taken to the quarterly QAPI meeting. Monitoring will be on-going quarterly.</p> <p>K 056 Corrective Action for Residents Affected: Our vendor (Koorsen Fire & Security) has been selected and their attached proposal states that they will have the identified complete automatic sprinkler system installed by 6/30/15 on our ambulance entrance canopy according to NFPA 13 standards. Other residents having the potential to be affected: All resident have the potential to be affected, however there was no actual harm to any. Measures to ensure practice does not reoccur: Vendor</p>	06/30/2015	

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K 062 SS=F Bldg. 02	<p>Findings include:</p> <p>Based on observation with the Director of Building Services and Maintenance Technician #1 at 04/28/15 at 1:24 p.m., there was a unsprinklered canopy extending forty feet from the building at the ambulance entrance. Based on an interview with the Director of Building Services and Maintenance Technician #1 at the time of observation, the canopy is sprinklered in the attic but the area below was noncombustible construction and the Director of Building Services stated sprinkler coverage was not required.</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>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 2-4.1.4 which requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers</p>	K 062	<p>selected with required sprinkler system to be installed by 6/30/15. Corrective Action will be monitored by: Our Maintenance Department will include the oversight of this additional sprinkler system within their Preventative Maintenance Program and our licensed Fire Safety Vendor will include this sprinkler system as part of their Quarterly Fire System Inspections.</p> <p>K 062 Corrective Action for Residents Affected By 05/28/2015 a supply of at least 6 spare sprinkler heads will be purchased and placed in the spare sprinkler cabinet. The light that was affecting the sprinkler head spray pattern in the Scheduler's office was moved on 4/30/2015.</p>	05/28/2015
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	<p>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 if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation with the Director of Building Services and Maintenance Technician #1 on 04/28/15 during a tour from 12:54 p.m. to 4:31 p.m., there were quick response sprinklers heads in the corridor of the healthcare building.</p> <p>Based on interview with Maintenance Technician #1 on 04/28/15 at 4:00 p.m., there was only one quick response sprinkler head available in the spare sprinkler cabinet.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 Scheduler's office sprinkler heads was unobstructed. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, Testing and</p>		<p>Other residents having the potential to be affected: All resident have the potential to be affected, however there was no actual harm to any.</p> <p>Measures to ensure practice does not reoccur: On 5/15/2015 the Maintenance Department was re-educated on K062 (See Attachment) The maintenance supervisor or designee will inspect and count the sprinkler heads weekly as part of their Preventative Maintenance Program.</p> <p>Corrective Action will be monitored by: The results of this count and inspection will be reviewed at our bi-monthly Safety Committee at which time any issues will be discussed and corrections confirmed. The results of this review will be presented quarterly to our QAPI meeting. Monitoring will be on-going.</p>				

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K 075 SS=E Bldg. 02	<p>Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice could affect residents in or near the Scheduler's office near the healthcare nurses' station.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Building Services and Maintenance Technician #1 on 04/28/15 at 2:57 p.m., the spray pattern for the Scheduler's office sprinkler head was obstructed by ceiling light fixture. Based on an interview with the Director of Building Services and Maintenance Technician #1 the ceiling light fixture was mounted one and one half inch from the sprinkler head.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p>			

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	<p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square feet area for 3 of 5 corridors. This deficient practice could affect 42 residents.</p> <p>Findings include:</p> <p>Based on observations with the Director of Building Services and Maintenance Technician #1 04/28/15 from 2:24 p.m. to 2:49 p.m., there were 2 sets of soiled linen/trash carts unattended and stored side by side in the corridor of the 2200, 2300 and 2400 halls. Additionally, there was a 44 gallon soiled linen container unattended and stored in the corridor of the 2300 hall and the 2400 hall. Based on an interview with Maintenance Technician #1 at the time of observations, the carts and containers stored in the corridors exceed the 32 gallons capacity within any 64 square feet area.</p> <p>3.1-19(b)</p>	K 075	<p>K075 Corrective Action for Residents Affected On 05/12/2015 an order was placed to purchase 32 gallon linen or trash barrels. The 42 gallon barrels were replaced with 32 gallon linen/trash barrels on 5/14/15. Placement of barrels or other collection receptacles will be monitored not to exceed 32 gallons within 64 square feet Other residents having the potential to be affected: All residents had the potential to be affected, however there was no actual harm to any.</p> <p>Measures to ensure practice does not reoccur: On 5/15/2015 the Laundry/Housekeeping/Nursing Departments were re-educated on K075 (See Attachment). The housekeeping supervisor or designee will inspect for compliance on routine rounds with their Housekeeping Compliance List.</p> <p>Corrective Action will be monitored by: The results of the Housekeeping Compliance List will be brought to the Safety Committee bi-monthly meeting at which time any issues will be discussed and corrected. The results of the review will then</p>	05/15/2015	

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K 076 SS=E Bldg. 02	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure combustible materials were separated from oxygen storage equipment in 1 of 1 oxygen storage areas. NFPA 99, the Standard for Health Care Facilities, Section 8-3.1.11.2(c)2 requires oxidizing gases such as oxygen shall be separated from combustibles by a minimum distance of five feet in a fully sprinklered building. This deficient practice could affect 13 residents in the 2200 hall.</p> <p>Findings include:</p> <p>Based on an observation with Maintenance Technician #1 on 04/28/15 at 2:15 p.m., a small trash can was stored within two inches of stationary liquid</p>	K 076	<p>be taken to the quarterly QAPI meeting. Monitoring will be on-going.</p> <p>K 076 Corrective Action for Residents Affected The trash can identified with this citation was removed on 4/28/2015 The facility will follow the NFPA guidelines related to oxygen storage. Other residents having the potential to be affected: All residents had the potential to be affected, however there was no actual harm to any. Measures to ensure practice does not reoccur: On 5/25/2015 the Housekeeping and Maintenance Departments were re-educated on K076(See Attachment) The Housekeeping Supervisor and Maintenance Director or their designee will inspect for compliance on routine rounds and will add the oxygen storage room to the Housekeeping Compliance List and Maintenance Preventative</p>	04/28/2015

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K 143 SS=E Bldg. 02	<p>oxygen containers in the oxygen storage room. Based on an interview at the time of observation, Maintenance Technician acknowledged there was paper trash in the trash can.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure oxygen stored in 1 of 1 sprinklered oxygen storage/transfer locations was at least 5 feet above the floor. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall</p>	K 143	<p>Maintenance Program. Corrective Action will be monitored by: The results of monitoring with the Housekeeping Compliance List and Maintenance Preventative Maintenance Program will be brought to the Safety Committee bi-monthly meeting at which time any identified issues will be discussed and corrections confirmed. The results of the review will then be taken to the quarterly QAPI meeting. Monitoring will be on-going.</p> <p>K 143 Corrective Action Taken for Resident Affected On 5/15/2015 the electrical switch and the electrical receptacle were moved to five feet above the floor in the oxygen storage room to meet NFPA Code. Other</p>	05/15/2015	

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K 147 SS=E Bldg. 02	<p>comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)(4) requires electrical fixtures, switches and outlets in oxygen storage locations be installed in fixed locations not less than 5 feet above the floor to avoid physical damage. This deficient practice could affect 13 residents in the 2200 hall.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Technician #1 on 04/28/15 at 12:00 p.m., the oxygen transferring room with at least two large liquid oxygen cylinders had one electrical switch on the wall four feet above the floor and one electrical receptacle on the wall 18 inches above the floor. Based on an interview at the time of observation, Maintenance Technician #1 acknowledged the switch and the receptacle were located within five feet above the floor.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords such as an extension cord were not used as a substitute for fixed wiring and 1</p>	K 147	<p>residents having the potential to be affected: No other residents were affected, and there was no actual harm to any Measures to ensure practice does not reoccur: On 5/15/2015 the Maintenance Department was re-educated on K143 (See Attachment) The maintenance supervisor or designee will inspect areas weekly as part of our Preventative Maintenance Program.</p> <p>Corrective Action will be monitored by: The results of this monitoring will be brought to the Safety committee bi-monthly meeting at which time any issues will be discussed and corrections reviewed. The results of this review will then be taken to the quarterly QAPI meeting. Monitoring will be on-going.</p> <p>K 147 All flexible-extension cords have been removed as per facility policy on 4/29/20015. All staff has been notified that extension cords must not be used</p>	05/20/2015			

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	<p>of 1 flexible cords were not used to provide power equipment with a high current draw. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure nor where run through doorways, windows, or similar openings. This deficient practice could affect 9 residents.</p> <p>Findings include:</p> <p>Based on an observation and interview on 04/28/15, the Director of Building Services and Maintenance Technician #1 acknowledged the following:</p> <p>a) at 1:18 p.m., a microwave was plugged in and supplied power by a extension cord power strip in the DON's office</p> <p>b) at 1:51 p.m., a regular light weight extension cord was providing power to a laptop in Therapy gym #2</p> <p>c) at 2:36 p.m., a regular light weight extension cord was providing power to a clock and another light weight extension cord was plugged into a extension cord power strip and providing power to a decorative house in resident room 2302</p> <p>d) at 1:24 p.m., there was a freezer in a</p>		<p>in any part of the facility. Other residents having the potential to be affected: All residents have the potential to be affected, however there was no actual harm to any. Measures to ensure practice does not reoccur: On 5/20/2015 our entire management team will be re-educated about K-0147 and that we cannot use extension cords in our facility. The maintenance supervisor or his designee will inspect areas weekly as part of our Preventative Maintenance Program. Corrective Action will be monitored by: The results of the Preventative Maintenance Program rounds will be brought by the maintenance supervisor or his designee to our bi-monthly Safety Meeting at which time any issues and corrections will be discussed. The results of this review will then be taken to the quarterly QAPI meeting. Monitoring will be on-going.</p>				

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	closet of the therapy gym. The closet lacked an electrical receptacle therefore the freezer was plugged into the wall outside the closet. The freezer electrical cord was molded into the shape of the door frame from repeatedly being shut in the door. 3.1-19(b)				