

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155743	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/13/2014
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NAME OF PROVIDER OR SUPPLIER GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/13/14</p> <p>Facility Number: 000288 Provider Number: 155743 AIM Number: 100287380</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Green-Hill Manor 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 consisted of the original building and a 1999 addition, all built prior to March 1, 2003, it was surveyed in accordance with LSC Chapter 19. The facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm</p>	K010000	<p>Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections 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 credible allegation of compliance.</p>	

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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K010018 SS=E	<p>system with hard wired smoke detection in the corridors, spaces open to the corridors and resident rooms 33 through 45. All other resident rooms were equipped with battery powered smoke detectors. The facility has the capacity for 64 and had a census of 28 at the time of this survey.</p> <p>All areas with customary access to residents and areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 11/21/14.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p>			

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	<p>Based on observation and interview, the facility failed to doors protecting corridor openings in 1 of 6 smoke compartments could resist the passage of smoke. This deficient practice affects visitors, staff and 10 or more residents in the east smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/13/14 at 11:45 a.m., the corridor opening to the office space adjacent to the east clean utility room was protected by a warped door. The top of the door was warped 3/4 inches between the door frame door stop and 1/2 inches between the top of the door and the door framed when the door was closed and latched. The maintenance director acknowledged at the time of observation, the door could not prevent the passage of smoke.</p> <p>3.1-19(b)</p>	K010018	<p>1. The gap in the door adjacent to the east clean utility room was immediately repaired to prevent the passage of smoke.</p> <p>2. All residents could have been affected by this deficient practice. The gap in the door adjacent to the east clean utility room was immediately repaired to prevent the passage of smoke.</p> <p>3. Upon exit of life safety specialist all doors in the facility were checked to ensure they prevented the passage of smoke with no further concerns identified. The Maintenance Supervisor was re-educated on the requirements of K 018. A quality assurance weekly monitoring form was implemented. The Maintenance Supervisor or Designee will be responsible to perform weekly checks on all doors in the facility to ensure they prevent the passage of smoke, and this deficient practice does not recur. Any concerns will be immediately corrected and findings will be reported to the Administrator.</p> <p>4. The weekly quality assurance monitoring forms will be reviewed during the Monthly Quality Assurance meetings and the plan adjusted accordingly to ensure that this deficient practice does not recur.</p>	12/13/2014	

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 exit doors with a delayed egress lock was readily accessible. LSC 7.2.1.6.1 Delayed Egress Locks allows approved, listed, delayed egress locks, shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected by a supervised automatic fire detection system installed in accordance with Section 9.6 or an approved or an approved supervised sprinkler system installed in accordance with 9.7, and where permitted in Chapters 12 through 42, provided:</p> <p>(a) The doors shall unlock upon actuation of an approved supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to release the device required in 7.2.1.5.4 that shall not</p>	K010038	<p>1. The Dining Room exit door has been repaired so that it will automatically release if force is applied for 15 seconds per requirement. 2. All residents could have been affected by this deficient practice. The dining room exit door has been repaired so that it will automatically release if force is applied for 15 seconds per requirement. 3. All exit doors equipped with magnetic lock features were tested and no further concerns were noted. The Maintenance supervisor was re-educated on the requirements of K 038. A quality assurance weekly monitoring form has been implemented. The Maintenance supervisor or designee will be responsible to perform weekly checks on all doors equipped with magnetic locks to ensure that they release if held by force for 15 seconds to meet requirements so this deficient practice does not recur. If any concerns are identified they will be corrected immediately and the Administrator will be notified. 4. The weekly quality assurance monitoring forms will be reviewed during the monthly Quality Assurance</p>	12/13/2014

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	<p>be required to exceed 15 lbf (67 (N) nor be 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 application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads: "PUSH Until ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS".</p> <p>This deficient practice affects staff, visitors, and 10 or more residents who use the dining room exit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/13/14 at 11:00 a.m., the dining room exit door was provided with a 15 second delay with proper signage but when force was applied to the releasing device on the door twice, an audible signal was not initiated and the door did not release.</p>		<p>Meetings and the plan adjusted accordingly to ensure that this deficient practice does not recur.</p>				

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K010046 SS=E	<p>The door was tested twice to ensure the 15 second delay worked and it failed each time. The maintenance director said at the time of observation, the exit door magnetic lock was designed to release upon activation of the fire alarm, a power outage, a code entered into the keypad adjacent to the exit door and pushing the door for 15 seconds. The other unlocking features were immediately tested with the maintenance director and the door unlocked.</p> <p>3.1-19(b)</p> <p>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.</p> <p>Based on observation and interview, the facility failed to ensure battery powered emergency lighting fixtures would operate in 1 of 6 smoke compartments. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors, staff and 10 or more residents in the north and northeast smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/13/14 at</p>	K010046	<p>1. The battery powered emergency light fixture located in the north exit corridor near room 33 was repaired and is now working correctly. 2. All residents could have been affected by this deficient practice. The battery powered emergency light fixture located in the north exit corridor near room 33 was repaired and is now working correctly. 3. All emergency lighting in the facility was checked and no other concerns were identified. The maintenance director was re-educated on the requirements of K 046. A</p>	12/13/2014			

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K010050 SS=F	<p>11:50 a.m., the battery powered emergency light fixture located in the north exit corridor near room 33 failed to illuminate when tested twice. The maintenance director acknowledged at the time of observation, the lights was not working.</p> <p>3.1-19 (b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could affect all residents, staff and visitors in the event of an emergency.</p>	K010050	<p>quality assurance weekly monitoring form has been implemented. The Maintenance director or designee will be responsible to test the emergency lighting fixtures weekly to ensure that this deficient practice does not recur. Any concerns will be immediately corrected and the Administrator will be notified.</p> <p>4. The weekly quality assurance monitoring forms will be reviewed during the monthly Quality Assurance Meetings and the plan will be adjusted accordingly to ensure that this deficient practice does not recur.</p> <p>1. The monthly fire drill was conducted on third shift during the second quarter of 2014 as required and the missing documentation was found in the maintenance office. 2. All residents could have been affected by this deficient</p>	12/13/2014	

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K010051 SS=F	<p>Findings include:</p> <p>Based on review of the facility's Monthly Fire Drills with the maintenance director on 11/13/14 at 3:10 p.m., there was no record of a third shift fire drill during the second quarter of 2014. The maintenance supervisor acknowledged at the time of observation, fire drill records accurately reflected the omission of the required fire drill.</p> <p>3.1-9(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's</p>		<p>practice. The monthly fire drill was conducted on third shift during the second quarter of 2014 as required and the missing documentation was found in the maintenance office. 3. The maintenance director was re-educated on the requirements of K 050. The maintenance director will now be responsible for maintaining all paperwork pertaining to fire drills in a manual in his office. The maintenance director or designee will also be required to provide a copy of each fire drill to the Administrator to ensure that this deficient practice does not recur. 4. The maintenance director will be responsible to bring a copy of each months fire drill to the monthly Q A meetings to ensure that the fire drill was completed as scheduled and that the proper paperwork is maintained in the manual.</p>		

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	<p>stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>1. Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 11/13/14 at 12:00 p.m., the maintenance director identified the emergency power circuit breaker panel in the north hall corridor. The panel, which included the Fire Alarm Circuit Panel (FACP) breaker was unsecured and unidentified. The fire alarm system circuit breaker located in the identified emergency power breaker box was identified but had no lock out on the circuit to prevent tampering. The</p>	K010051	<p>1. The fire alarm circuit breaker panel in the north hall corridor which includes the FACP breaker has now been properly identified and secured. 2. All residents could have been affected by this deficient practice. The fire alarm circuit breaker panel located in the north hall corridor which includes the FACP breaker has now been properly identified and secured. 3. The Maintenance Director was re-educated on the requirements of K-051. A quality assurance weekly monitoring form has been implemented. The maintenance director or designee will be responsible to ensure that the fire alarm circuit panel remains identified and secured weekly so that the deficient practice does not recur. Any concerns will be immediately corrected and the Administrator will be notified. 4. The weekly quality assurance monitoring forms will be reviewed monthly during the quality assurance meetings and the plan will be</p>	12/13/2014	

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	<p>maintenance director acknowledged at the time of observation, there was no means to identify the circuit panel and the panel was easily accessible for unauthorized persons.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure documentation for the testing of 1 of 1 fire alarm systems components and devices, such as, smoke detectors, heat sensors and fire alarm pull stations was complete. NFPA 72, 7-3.2 requires fire alarm system devices, such as, smoke detectors, heat sensors, fire alarm pull stations, and fire alarm control equipment be tested annually. The inspection should include locations and serial numbers, the test/inspection done and whether each device passed or failed. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the facility's annual Fire Alarm System Test Report dated 03/11/14 with the maintenance director on 11/13/14 at 2:20 p.m., there was no itemized list of the fire alarm system components and devices, such as, smoke detectors, horn/strobe devices,</p>		<p>adjusted accordingly to ensure that this deficient practice does not recur.</p>				

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K010054 SS=F	<p>door holder devices, and manual pull stations, with the locations and results of the visual and functional tests. The maintenance director confirmed, at the time of record review there was no itemized documentation available listing test results of all components and devices of the fire alarm system on any fire alarm inspection report for the past year.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 Based on record review and interview, the facility failed to ensure 19 of 19 smoke detectors connected to the fire alarm system had been sensitivity tested. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate that the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be</p>	K010054	<p>1. The missing smoke detector inspection reports concerning sensitivity testing was located in the maintenance office.</p> <p>2. All residents could have been affected by this deficient practice. The missing smoke detector inspection reports concerning sensitivity testing was located in the maintenance office.</p> <p>3. The maintenance director was re-educated on the requirements of K-054. The maintenance director will now be responsible for maintaining all required paperwork in a manual in his office. The maintenance director will now be required to provide a copy of said paperwork to the</p>	12/13/2014			

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	<p>extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <ol style="list-style-type: none"> (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 acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector." This deficient practice affects all occupants.</p>		<p>Administrator to ensure that this deficient practice does not recur. 4. The maintenance director will be responsible to bring the manual to the monthly quality assurance meetings to ensure that the proper paperwork is maintained in the manual so this deficient practice does not recur.</p>				

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K010062 SS=E	<p>Findings include:</p> <p>Based on a review of the facility smoke detector Inspection Reports with the maintenance director on 11/13/14 at 2:20 p.m., the last record of sensitivity testing was dated 03/27/12. The maintenance director confirmed at the time of record review, there was no current record of sensitivity testing and acknowledged the sensitivity testing was overdue.</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 ensure sprinkler heads in 1 of 2 activity rooms were free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice affects visitors, staff and 10 or more residents on the west wing.</p>	K010062	<p>1. The four light fixtures located in the west Activity room were moved away from the sprinkler heads to prevent obstruction and allow the spray pattern to cover the 14 foot center of the unprotected room. The paint was removed from the sprinkler heads near rooms 10,28, 30, 35, and near the south nurse's station, south mechanical room,northeast med room. The sprinkler heads located in the southwest shower room and east bathroom were cleaned of corrosion. The sprinkler head</p>	12/13/2014			

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NAME OF PROVIDER OR SUPPLIER GREEN-HILL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944		
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	<p>Findings include:</p> <p>Based on observation with the maintenance director on 11/13/14 at 12:30 p.m., the west activity room was protected by four pendant sprinkler heads. Four fluorescent ceiling light fixtures were located two and three inches from each of the sprinklers. The light fixtures extended three inches from the ceiling. The maintenance director acknowledged at the time of observation, the size and locations of the light fixtures obstructed all four of the sprinkler heads and effectively left the 14 foot center of the room unprotected.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure sprinkler heads in 3 of 6 smoke compartments were free of foreign materials, such as paint, grime, and corrosion. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects could affect visitors, staff, and 10 or more residents in the southeast, south, and west smoke smoke compartments.</p> <p>Findings include:</p>		<p>located in the south west bathroom was replaced. The sprinkler head located in the south west soiled utility room was cleaned. 2. All residents could have been affected by this deficient practice. The four lights located in the west activity room were moved away from the sprinkler heads to prevent obstruction and allow the spray pattern to cover the 14 foot center of the unprotected room. The paint was removed from the sprinkler heads near room 10, 28, 30, 35, and near the south nurse's station, south mechanical room, north east med room. The sprinkler heads located in the southwest shower room and east bathroom were cleaned of corrosion. The sprinkler head located in the south west bathroom was replaced. The sprinkler head located in the south west utility room was cleaned. 3. The maintenance director was re-educated on the requirements of K 062. A monthly quality assurance monitoring form has been implemented. The maintenance director or designee will be responsible to check all sprinkler heads in the facility each month to ensure they remain free from dirt, fuzz, grime, corrosion, and rust, and</p>		

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K010064 SS=B	<p>Based on observation with the maintenance director on 11/13/14 between 10:30 a.m. and 1:30 p.m.:</p> <p>a. Corridor sprinkler heads near rooms 10, 28, 30, 35 and sprinkler heads near the south nurses station, south mechanical room and northeast medicine room had paint on the brackets, deflectors and/or sprinkler bulb.</p> <p>b. The sprinkler heads protecting the southwest shower room and east bathroom were turning green, usually evidence of corrosion.</p> <p>c. The sprinkler head protecting the southwest bathroom was corroded with rust.</p> <p>d. The sprinkler head protecting the southwest soiled utility room was coated with a fuzzy gray film and was turning green. The maintenance director acknowledged at the time of observations, the sprinkler heads were not in good condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the</p>	K010064	<p>also ensure that they are not obstructed by any fluorescent lights to ensure that this deficient practice does not recur. Any concerns will be immediately corrected and reported to the Administrator.</p> <p>4. The maintenance director will be responsible to bring the quality assurance monitoring forms to the monthly quality assurance meetings for review and the plan will be adjusted accordingly to ensure that this deficient practice does not recur.</p> <p>1. The portable ABC fire</p>	12/13/2014			

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K010073 SS=C	<p>facility failed to ensure all fire extinguishers in 1 of 5 smoke compartments were installed as required. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires that the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be no more than three and one half feet (42 inches) above the floor. This deficient practice affects 4 or more visitors and staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director 11/13/14 at 10:50 a.m., the portable ABC fire extinguisher in the kitchen was measured at 62 inches above the finished floor. The maintenance director said at the time of observation he was unaware there was a height limit for fire extinguishers mounted to the wall.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 Based on observation and interview, the facility failed to ensure flammable</p>	K010073	<p>extinguisher in the kitchen was lowered to the proper height.</p> <p>2. All residents could have been affected by this deficient practice. The portable ABC fire extinguisher in the kitchen was lowered to the proper height.</p> <p>3. The maintenance director was re-educated on the requirements of K 064. A monthly quality assurance monitoring form has been implemented. The maintenance director or designee will be responsible to check all portable fire extinguishers in the facility each month to ensure that this deficient practice does not recur. Any concerns will be immediately corrected and reported to the administrator. 4. The maintenance director will be responsible to bring the monthly quality assurance forms to the quality assurance meetings each month for review and the plan adjusted accordingly to ensure that this deficient practice does not recur.</p> <p>1. The candles that were located on the cupboard in the</p>	12/13/2014	

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K010144 SS=C	<p>decorations were not available for use in 1 of 6 smoke compartments. This deficient practice could affect visitors, staff and 10 or more residents in the dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/13/14 at 2:15 p.m., three wicked candles were located on a cupboard in the dining room with paper holiday decorations. The maintenance director acknowledged at the time of observation the candles were an inherently flammable decoration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on interview, the facility failed to ensure the off-site fuel source for 1 of 1 emergency generators was from a reliable</p>	K010144	<p>main dining room have been removed. 2. All residents could have been affected by this deficient practice. The candles that were located on the cupboard in the main dining room have been removed. 3. The maintenance director was re-educated on the requirements of K 073. A monthly quality assurance monitoring form has been implemented. The maintenance director or designee will be responsible to conduct monthly rounds to ensure that this deficient practice does not recur. Any concerns will be immediately corrected and findings will be reported to the Administrator. 4. The maintenance director will be responsible to bring the monthly quality assurance monitoring forms to the quality assurance monthly meetings for review and the plan adjusted accordingly to ensure that this deficient practice does not recur.</p> <p>1. The letter from the facility's natural gas provider has been obtained, stating that the fuel source for the generator was a</p>	12/13/2014	

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	<p>source. NFPA 110, 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <p>a) Liquid Petroleum products at atmospheric pressure</p> <p>b) Liquefied petroleum gas (liquid or vapor withdrawal)</p> <p>c) Natural or synthetic gas</p> <p>Exception: For Level 1 installations in locations where the probability of interruption of off--site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview with the maintenance director on 11/13/14 at 10:55 a.m., the fuel source for the emergency generator was natural gas. The maintenance</p>		<p>reliable source. 2. All residents could have been affected by this deficient practice. The letter from the facility's natural gas provider has been obtained, stating that the fuel source for the generator was a reliable source. 3. The maintenance director was re-educated on the requirements of K 144. A monthly quality assurance monitoring form has been implemented. The maintenance director will be responsible to keep this monitoring form updated each month to ensure that the facility receives an annual letter from the facility's natural gas provider stating that the fuel source for the generator was a reliable source. 4. The maintenance director will be responsible to bring this monthly quality assurance monitoring form to the monthly quality assurance meetings for review to ensure that this deficient practice does not recur.</p>				

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K010147 SS=E	<p>director confirmed at the time of observation natural gas was the only fuel source for the emergency generator. During a review of fire safety records and with the maintenance director on 11/13/14 at 2:10 p.m., no record ensuring of the reliability of the natural gas fuel supply was found. The maintenance director said at the time of record review he did not have a letter from the facility natural gas provider stating the fuel source for the generator was a reliable source.</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 flexible cords were not used as a substitute for fixed wiring in 2 of 6 smoke compartments. 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 fixed wiring of a structure. This deficient practice could affect 10 or more residents, staff, and visitors in the east and south smoke compartments.</p> <p>Findings include:</p>	K010147	<p>1. The extension cords were removed from the dietary storage room, room 43, the east clean utility room, and the power strip extension cord above the south east exit door.</p> <p>2. All residents could have been affected by this deficient practice. The extension cords were removed from the dietary storage room, room 43, the east clean utility room, and the power strip extension cord above the south east exit door.</p> <p>3. The maintenance director was re-educated on the requirements of K 147. A</p>	12/13/2014			

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	<p>a. Based on observation with the maintenance director on 11/13/14 at 10:40 a.m., an extension cord was used to supply power to an electric water heater in the dietary storage room, a TV in resident room 43. and the ice machine in the east clean utility room. The maintenance director acknowledged the use of the extension cords to supply power in each of the areas.</p> <p>b. Based on observation with the maintenance director on 11/13/14 at 11:10 a.m., a power strip extension cord ran from the attic space above the southeast exit door and was mounted above the door, behind the illuminated light fixture. Two small boxes were plugged into the power strip. The maintenance director said at the time of observation, he did not know, where the power strip was plugged in and didn't know what was being powered by it.</p> <p>3.1-19(b)</p>		<p>weekly quality assurance monitoring form has been implemented. The maintenance director or designee will be responsible to ensure that weekly rounds are conducted throughout the facility to ensure that this deficient practice does not recur. Any concerns will be immediately corrected and the administrator will be notified.</p> <p>4. The maintenance director will be responsible to bring these weekly quality assurance monitoring forms to the monthly quality assurance meetings for review and the plan adjusted accordingly to ensure that this deficient practice does not recur.</p>				