

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155228	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/17/2015
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NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 2070 CHESTER BLVD RICHMOND, IN 47374
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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: 09/17/15</p> <p>Facility Number: 000133 Provider Number: 155228 AIM Number: 100266080</p> <p>At this Life Safety Code survey, Heritage House of Richmond 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 V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 87 and had a census of 59 at the time of this visit.</p>	K 0000	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.</p> <p>Please accept this Plan of Correction as Credible Allegations of Compliance. We respectfully ask your consideration for paper 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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K 0018 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has two detached wooden storage sheds which are not sprinkled.</p> <p>Quality Review completed on 09/21/15 - 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 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. 1. Based on observation and interview, the facility failed to ensure there were no impediments to the closing of 1 of 1 activities room doors and 1 of 1 conference room doors protecting corridor openings. This deficient practice could affect 27 residents in 2 of 8 smoke compartments.</p>	K 0018	<p>K018</p> <p>It is the policy of this facility that all doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1.3/4" solid bonded core wood or</p>	10/13/2015

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	<p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Maintenance on 9/17/15 at between 10:03 a.m. and 12:11 p.m., the corridor doors to the conference room and activities room were obstructed by a trash can propping the doors open. Based on interview at the time of observation, this was acknowledged by the Director of Maintenance.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 8 closet corridor doors closed and latched into the door frame. This deficient practice could affect 18 residents on the northwest hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Maintenance on 09/17/15 at 11:14 a.m., the corridor door to the linen closet on the Northwest hall failed to latch into the door frame. Based on interview, this was acknowledged by the Director of Maintenance at the time of observations.</p> <p>3.1-19(b)</p>		<p>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 closing of the doors. Doors are provided with a means suitable for keeping the door closed.</p> <p>While there were 27 residents in one situation and 18 residents in the other with the potential to be affected, no residents were directly affected.</p> <p>The trash cans were removed during time of survey so that the doors were no longer blocked. The door of the northwest closet door will be repaired to assure it latches into the frame.</p> <p>All staff were inserviced on 9/28/15 on not blocking doors with items.</p> <p>Managers while doing rounds will check that all closet doors latch into frame and doors are not blocked by trash cans daily for the next week, twice weekly for the following two weeks and weekly thereafter. If any issues arise maintenance will immediately address the issue then and will report those findings to the administrator. Issues will be brought to QA committee quarterly to determine if any systematic changes need to be addressed. This facility will follow all recommendations of the QA committee.</p>	

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K 0021 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>1. Based on observation and interview, the facility failed to ensure the 2 of 4 corridors doors to hazardous areas, such as room with a hot water heater, would self close and latch into the frame. This deficient practice could affect 28 residents in 2 of 8 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Maintenance on 09/17/15 between 10:00 a.m. and 12:30 p.m., the following hazardous areas with a hot water heater failed to self close and latch into the frame:</p> <p>a) The corridor door of the maintenance room was equipped with kick down door</p>	K 0021	<p>Date of completion: 10/13/15</p> <p>K021</p> <p>It is the practice of this facility that any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of the fire alarm, smoke detection system, and sprinkler system.</p> <p>There were 28 and 50 residents, respectively, who had the potential to be affected; however, no residents were directly affected.</p> <p>Repairs were made to the</p>	10/13/2015	

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	<p>stop preventing the door from automatically closing.</p> <p>b) The corridor door of the northwest mechanical room equipped with a self closer that would not close when pushed fully open.</p> <p>Based on interview, this was acknowledged by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 serving window double doors to the kitchen with a self closing device would cause the door to automatically close and latch into the door frame. This deficient practice can affect 50 residents using the dining room and staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Maintenance on 09/17/15 at 12:35 p.m.; the double doors covering the service window from the kitchen to dining room which was open to the corridor were equipped with self closing devices. The first of the double doors was equipped with an automatic latch that failed to latch into the frame. Also, that door was equipped with an astragal. Because there was not a</p>		<p>maintenance door stop, the northwest mechanical door self-closer, and the double doors covering the service window. All other doors with the potential to be affected were checked and repairs made if needed.</p> <p>Managers while making morning rounds will check the doors to ensure that they are functioning properly. All problems with the door will be immediately brought to the Maintenance Supervisor and/or Administrator. Any doors or closers that need to be replaced will be replaced and any that can be repaired will be repaired immediately. Any issues that exist will be brought to review at quarterly QA for the next six months. If any systematic changes need to be put into place, this facility will follow all recommendations of the QA committee.</p> <p>Date of completion: 10/13/15</p>				

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K 0022 SS=E Bldg. 01	<p>door coordinator installed, the door with the astragal would close first preventing the second door from latching into the first door. Based on interview at the time of observation, the Director of Maintenance acknowledged the doors did not properly latch into the frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 1 of 1 doors likely to be mistaken for a way of exit from the dining room was identified as "No Exit". LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads: NO Exit. This deficient practice could affect all up to 50 resident in the dining room</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Director of Maintenance on 09/17/15 at 11:00 a.m.,</p>	K 0022	<p>K022</p> <p>It is the policy of this facility that access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants.</p> <p>There were 50 residents who had the potential to be affected; however, no residents were directly affected.</p> <p>A sign was placed on the dining room patio door identifying it as "no exit". All other exterior doors were checked by Maintenance Supervisor to assure they had proper signage in</p>	10/13/2015

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K 0027 SS=E Bldg. 01	<p>there was a sliding glass door that cannot be used as an egress door in the dining room that lacked a sign that identified the door as not an exit. Based on interview at the time of observation, the Director of Maintenance acknowledged the door was not identified.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 3 of 14 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC</p>	K 0027	<p>place.</p> <p>If any new entrances/exits are put into the building the maintenance supervisor and/or administrator will assure that proper signage exits. Managers while doing rounds will look for any areas that could be confusing. If anything exists Maintenance supervisor and/or administrator will immediately fix. These issues will be brought to quarterly QA for the next six months, this facility will follow all recommendations of the QA committee.</p> <p>Date of completion: 10/13/15</p> <p>K027</p> <p>It is the practice of this facility to maintain smoke barrier doors in accordance with NFPA 101 Life Safety Code Standard.</p>	10/13/2015

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	<p>Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 12 residents in 2 of 8 smoke compartments and anyone working in the attic.</p> <p>Finding includes:</p> <p>Based on observation during a tour of the facility with the Director of Maintenance on 09/17/15 between 10:09 a.m. and 12:10 p.m., the following was noted</p> <p>a) The Far East smoke barrier doors had a one fourth inch gap between the doors when closed.</p> <p>b) The east smoke barrier door in the attic was rubbing on the floor preventing the door from self closing leaving a 12 inch gap. Also, the door had a one half inch gap when closed due to a cable running through the opening not allowing the door to completely shut.</p> <p>c) The southeast smoke barrier door in the attic was rubbing on the floor preventing the door from self closing leaving a 12 inch gap. Also, the door had a two inch gap at the bottom when closed due to the door cut short to allow room for a sprinkler line.</p> <p>Based on an interview, the Director of Maintenance acknowledged and provided</p>		<p>There were 12 residents who had the potential to be affected; however, no residents were directly affected.</p> <p>Repairs were made to the smoke barrier door on the far east side, the east smoke barrier door in the attic, and the southeast barrier door in the attic. All other doors with the potential to be affected were checked and if needed repairs would be or will be made.</p> <p>Doors will be checked for proper closing when conducting the monthly fire drill.</p> <p>This will be monitored by Maintenance Supervisor and/or Administrator for six months and the results taken to QA. If any systematic changes need to be put in place then this facility will follow all recommendations of the QA committee.</p> <p>Date of completion: 10/13/15</p>	

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K 0029 SS=E Bldg. 01	<p>measurements of the gaps in the smoke doors at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 3 of 4 a hazardous areas, such as a boiler room, was smoke resistive. This deficient practice could affect 40 residents in 3 of 8 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Maintenance on 09/17/15 between 10:00 a.m. and 12:30 p.m., the fowling hazardous areas had penetrations sealed with an unapproved material:</p> <p>1) In the maintenance room, which</p>	K 0029	<p>K029</p> <p>It is the practice of this facility to follow the NFPA 101 Life Safety Code Standard in providing smoke resistant partitions in areas.</p> <p>There were 40 residents who had the potential to be affected; however, no residents were directly affected.</p> <p>The maintenance supervisor fixed all the wall penetrations that had previously been filled with the gray fire caulk. All penetrations were subsequently filled with new caulk that meets the Life Safety Code</p>	10/13/2015

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K 0038 SS=E Bldg. 01	<p>contained a hot water heater, there were nine penetrations around pipes sealed with a gray caulk.</p> <p>2) In the east side mechanical room, which contained a hot water heater, there were three penetrations around pipes sealed with a gray caulk.</p> <p>3) In the northwest mechanical room, which contained a hot water heater, there were ten penetration around pipes sealed with a gray caulk.</p> <p>Based on interview at the time of observation, the Director of Maintenance stated he did not fill the penetrations but had a tube of the gray fire caulk that was used. Based on review of the fire caulk tube with the Director of Maintenance at 10:15 a.m., the fire caulk was rated as ASTM E-136 as a residential fire caulk not meeting the requirements for use in through penetration fire stop systems for health care facilities.</p> <p>3.1-19(b)</p> <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 8 exit discharge paths was readily accessible at</p>	K 0038	<p>standard.</p> <p>The maintenance supervisor and managers will continue to monitor while doing morning rounds and inspections of the building for any areas of gap in fire protection and/or the wrong type of fire protection. Any sections missing caulking and/or with the wrong type will be immediately fixed. Maintenance supervisor will do quarterly checks on the fire gaps/wall penetrations to ensure they are properly fire stopped. Any issues will be brought to the quarterly QA committee for review for the next six months and this facility will follow all recommendations of the QA committee on any systematic changes needed.</p>	10/13/2015			

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	<p>all times. This deficient practice could affect 25 residents in the southwest hallway in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Maintenance on 09/17/15 at 12:14 p.m., the southwest hall exit door required an extra step to get the door opened after the magnetic lock was released. When the panic bar was pushed to open the door after the magnetic lock was released, the door did not open. A latch at the top of the door had to be depressed in order for the door to open. Based on an interview at the time of observation the Director of Maintenance said, "The panic bar must be broken and I will have to fix the door."</p> <p>3.1-19(b)</p>		<p>It is the policy of this facility to insure that exit access is arranged so that exits are readily accessible at all times in accordance with NFPA 101 Life Safety Code Standard.</p> <p>There were 25 residents that had the potential to be affected; however, no residents were directly affected.</p> <p>The maintenance supervisor will fix and/or replace the southwest hall exit door in order to assure it opens with the pressing of the panic bar. All other exit doors will be checked to assure they are working properly, any doors needing repair or to be replaced will be at that time.</p> <p>Maintenance supervisor will check all exit doors to assure their proper operation weekly</p>	

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K 0048 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to provide a written plan that included the activation of a resident room battery operated smoke detector in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <p>(1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms</p>	K 0048	<p>for the next month and monthly thereafter during fire drills. Any doors failing to operate as designed will be repaired or replaced immediately. Any issues will be brought to quarterly QA for the next six months for review, the facility will follow the recommendations of the QA committee on any systematic changes.</p> <p>Date of completion: 10/13/15</p> <p>K048 It is the policy of this facility that there is a written plan for the protection of all patients and for their evacuation in the event of an emergency. All the residents had the potential to be affected; however, no residents were directly affected. The facility had a policy in place that the maintenance director wasn't aware of location when speaking to the life safety inspector regarding the battery operated smoke detectors. In our battery-operated smoke detector</p>	10/13/2015

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K 0050 SS=F Bldg. 01	<p>(4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all residents.</p> <p>Findings include:</p> <p>Based on a record review of the "Fire Policy and Procedure" with Director of Maintenance on 09/17/15 at 9:35 a.m., the plan did not address response to the activation of a resident room battery operated smoke detector. Based on interview, this was acknowledged by the Director of Maintenance at the time of record review.</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</p> <p>1. Based on record review and interview,</p>	K 0050	<p>policy it states, "That if a smoke detector(s) is activated, the staff will respond in accordance to a separate policy(s) for "Fire Policy and Procedure" (See Attachment 1 and 2). Every employee will continued to be trained upon hire and ongoing thereafter. All employees will be in-serviced on the battery-operated smoke detector policy on 9/28/15 and continuously with our disaster planning thereafter. Any issues with the battery-operated smoke detectors and/or the policy will immediately be brought to the attention of the maintenance director and/or administrator to be fixed. All issues will be brought to QA quarterly for the next six months, if systematic changes are needed this facility will follow all recommendations of the facility QA committee. Date of completion: 10/13/15</p>	10/13/2015			

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	<p>the facility failed to ensure fire drills were conducted quarterly on each shift for 2 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Fire Drill Report" with the Director of Maintenance on 09/17/15 at 08:50 a.m., there was no record of the following fire drills:</p> <p>a) A second shift fire drill for the first quarter of 2015.</p> <p>b) A third shift fire drill for the fourth quarter of 2014.</p> <p>c) A first shift fire drill for the fourth quarter of 2014.</p> <p>Based on an interview at the time of record review, the Director of Maintenance confirmed the missing drills and stated no other documentation was available for review to verify this drill was conducted.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to conduct quarterly fire drills for third shift at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants.</p>		<p>K050</p> <p>It is the policy of this facility to hold fire drills according to NFPA 101 Life Safety Code Standard. These drills are to be held under varying conditions, at least quarterly on each shift.</p> <p>All occupants had the potential to be affected; however, no residents were directly affected by this.</p> <p>The facility will continue to conduct fire drills quarterly on each shift at random times. The maintenance supervisor will bring all fire drill reports to the administrator for approval of the time. If found to not be random enough the administrator will instruct the maintenance supervisor to hold another drill.</p>		

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K 0074 SS=B Bldg. 01	<p>Findings include:</p> <p>Based on record review of the "Fire Drill Record" forms with the Director of Maintenance on 09/17/15 at 8:50 a.m., the following was noted:</p> <p>a) All third shift fire drills took place between 10:15 p.m. and 11:30 p.m. for the last four quarters.</p> <p>b) All second shift fire drills took place between 2:00 p.m. and 3:49 p.m. for the last four quarters.</p> <p>Based on interview, this was confirmed by the Director of Maintenance at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p>		<p>All fire drills will be discussed during the quarterly QA. Any recommendations of systematic changes by the committee will be followed.</p> <p>Date of completion: 10/13/15</p>		

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	<p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 sets of curtains located on the windows of three exit doors were flame retardant. This deficient practice could affect 42 residents in 3 of 8 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Director of Maintenance on 09/17/15 between 10:13 a.m. and 11:43 p.m., there were two sets of curtains covering the windows on the east, west, and southwest exit doors. Upon inspection of the curtains, no flame retardant rating was found. Based on interview at the time of observation, the Director of Maintenance indicated there was no documentation regarding flame retardants for the curtains.</p> <p>3.1-19(b)</p>	K 0074	<p>K074</p> <p>It is the policy of this facility to follow NFPA 101 Life Safety Code Standards in regards to the fire protection of draperies, curtains, including cubicle curtains or other loosely hanging fabrics and films serving as furnishings or decorations.</p> <p>There were 42 occupants who had the potential to be affected; however, no occupants were directly affected.</p> <p>All the curtains that didn't meet NFPA 101 guidelines were either replaced or sprayed with the appropriate fire retardant spray in order to meet the NFPA 101</p>	10/13/2015

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K 0076 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater		guidelines. The maintenance director will continue to inspect all draperies, curtains, and other loosely hanging fabrics that are brought into the building. If those materials already don't meet the NFPA 101 guidelines the maintenance director will either replace them or spray them with the appropriate fire retardant spray. Maintenance director will keep a log of the items sprayed and the chemical used on the items. Date of completion: 10/13/15	

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	<p>than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 electrical outlets in the oxygen storage room was located at least five feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)1(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage. This deficient could affect 15 residents in 1 of 8 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Maintenance at 10:11 p.m. on 09/17/15, there was one electrical outlet, a light switch, on the wall in the oxygen storage room less than five feet above the floor of the oxygen storage room located by room 37. Based on interview at the time of observation, the Director of Maintenance acknowledged the electrical outlet on the wall was less than five feet above the floor in the oxygen storage room.</p> <p>3.1-19(b)</p>	K 0076	<p>K076</p> <p>It is the policy of this facility that all medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>There were fifteen and two residents who had the potential to be affected; however, no residents were actually affected.</p> <p>The maintenance supervisor raised the level of the light switch so that it met the appropriate guidelines of the Life Safety Code. It is now above the 5' threshold. The loose oxygen cylinder was not an asset of this facility. This facility only uses encased portable oxygen, not the loose cylinders. Hospice was</p>	10/13/2015

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K 0130 SS=F Bldg. 01	<p>2. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen cylinders in room 15 was properly restrained. NFPA 99, Section 8-3.1.11.2(h) requires cylinder restraint to meet the requirements of Section 4-3.5.2.1(b) 27 which requires freestanding cylinders to be chained or supported in a cylinder stand or cart. This deficient practice could up to 2 residents in room 15.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Director of Maintenance on 09/17/15 at 10:11 a.m., there was an unsupported portable cylinder of compressed oxygen on the floor of room 15. Based on interview, this was acknowledged by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 52 of 52 resident</p>	K 0130	<p>notified their driver forgot one of their oxygen cylinders.</p> <p>Maintenance supervisor and medical supply supervisor will ensure that all oxygen that is brought into this facility for a hospice patient comes with the required rack to meet the Life Safety Code guidelines. Managers will look for any loose oxygen tanks while doing rounds. Any loose tanks will be secured or removed.</p> <p>Date of completion: 10/13/15</p> <p>K130</p> <p>It is the policy of this facility to maintain a maintenance plan</p>	10/13/2015

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	<p>sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained. LSC 9.6 states a fire alarm shall be installed, tested, and maintained to NFPA 72, National Fire Alarm Code. This deficient practice affects all occupants of the facility.</p> <p>Findings include:</p> <p>Based on records review of the "Smoke Detector Monthly Check List" with the Director of Maintenance on 09/17/15 at 9:10 a.m., there was no indication that the battery operated smoke alarms located in the residents' rooms were cleaned according to manufacturer's cleaning recommendations. Based on an interview during records review, the Director of Maintenance stated the manufacturer's cleaning recommendations was to be conducted annually. Also, the Director of Maintenance confirmed each resident room was equipped with a battery operated smoke alarms and was unable to provide any documentation to show cleaning was conducted since June of 2012.</p> <p>3.1-19(b)</p>		<p>according to the manufacturer's guidelines.</p> <p>All the residents had the potential to be affected; however, no residents were directly affected.</p> <p>Maintenance has cleaned all the battery operated smoke detectors per the manufacturer's guidelines. Maintenance supervisor or designee will continue to clean the battery operated smoke detectors per manufacturer's guidelines annually, unless stated otherwise, when contracted company performs their annual inspection of smoke detectors.</p> <p>Date of completion: 10/13/15</p>	

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K 0147 SS=E Bldg. 01	<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 4 of 4 flexible cords in the facility were not used as a substitute for fixed wiring to provide power for medical equipment and 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 fixed wiring of a structure. This deficient practice could affect 4 residents in rooms 23 and 47, and staff in the house keeping and maintenance office.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Director of Maintenance on 09/17/15 between 10:12 a.m. and at 11:52 a.m., the following medical equipment or equipment with a high current draw were plugged into power strips</p> <p>a) In resident room 47 a nebulizer and an oxygen concentrator were supplied with electricity by extension cord power strip. b) In resident room 23 a nebulizer was supplied with electricity by extension</p>	K 0147	<p>K147</p> <p>It is the policy of this facility to not use flexible cords in the facility as a substitute for fixed wiring to provide power for medical equipment and equipment with a high current draw.</p> <p>There were four residents and staff in two different offices who had the potential to be affected; however, no residents or staff were directly affected.</p> <p>The four flexible cords were removed from being in use. They no longer have the potential to affect anyone. All other rooms were checked for improperly used cords.</p>	10/13/2015

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	<p>cord power strip.</p> <p>c) In the maintenance office a refrigerator and microwave were supplied with electricity by extension cord power strip.</p> <p>d) In the house keeping office a coffee pot, refrigerator, and microwave were supplied with electricity by extension cord power strip.</p> <p>Based on interview, the Director of Maintenance acknowledged the extension cord power strip at the time of observation.</p> <p>3.1-19(b)</p>		<p>The maintenance supervisor will approve the use of any electrical cord in order to maintain that it meets the Life Safety Code requirements. The maintenance supervisor will do monthly audits of rooms to ensure no devices are in use that would not meet the Life Safety Code standard. The results of the audits will be reviewed by the QA committee and any recommendations will be followed.</p> <p>Date of completion: 10/13/15</p>	