

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155793	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/14/2014
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NAME OF PROVIDER OR SUPPLIER  HAMILTON TRACE OF FISHERS	STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037
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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: 03/14/14</p> <p>Facility Number: 012644 Provider Number: 155793 AIM Number: 201046710</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hamilton Trace of Fishers 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 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke</p>	K010000	<p>March 27, 2014</p> <p>Kim Rhoades, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204</p> <p>Re: Allegation of Compliance</p> <p>Dear Ms. Rhoades:</p> <p>Please find enclosed the Plan of Correction to the annual Life Safety Code Survey conducted on March 14, 2014. This letter is to inform you that the plan of correction attached is to serve as Hamilton Trace's credible allegation of compliance. We allege compliance on April 13, 2014.</p> <p>If you have any further questions,</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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	<p>detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 108 and had a census of 101 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>		<p>please do not hesitate to contact me at (317) 813-4444.</p> <p>Sincerely,</p> <p>Melissa Hampton, HFA Administrator</p>		

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			<p>Submission of this plan of correction in no way constitutes an admission by Hamilton Trace of Fishers of or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care other services provided in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. Hamilton Trace of Fishers reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts, and conclusions that form the basis of the deficiency. This plan of correction serves as the allegation of compliance by April 13, 2014.</p> <p>This statement of deficiencies and plan of correction will be reviewed at the May Quality Assurance/Assessment Committee meeting.</p>		

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K010027 SS=F	<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. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8</p> <p>Based on observation and interview, the facility failed to ensure 6 of 8 sets of smoke barrier doors would close to form a smoke resistant barrier. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 3:10 p.m. on 03/14/14, the set of smoke barrier doors in the corridor by Room 301, from Memory Care to the 400 Hall, at the entrance to Assisted Living, by Room 601, from the 700 Hall to the 800 Hall, by Room 801 each swing in the opposite direction and are not equipped with an astragal, rabbet or bevel at the meeting edge. In addition, the top of the north door in the set of smoke barrier doors</p>	K010027	<p><b>K27 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b> An astragal, rabbet or bevel at the meeting edge have been ordered for smoke barrier doors by Room 301, from Memory Care to 400 hall, at the entrance to Assisted Living, by 601, from 700 hall to the 800 hall, and by room 801 and installation has been scheduled. The set of smoke barrier doors outside of 700/800 hallway were readjusted.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> All residents have the potential to be affected. <b>III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b> During monthly fire alarm checks the Maintenance Director or designee will monitor</p>	04/13/2014

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K010029 SS=F	<p>from the 700 Hall to the 800 Hall hit the door frame when tested and did not fully close leaving a one inch gap. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned smoke barrier door sets each swing in the opposite direction, are not equipped with an astragal, rabbet or bevel and the north door in the set of smoke barrier doors from the 700 Hall to the 800 Hall did not fully close leaving a one inch gap.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 1. Based on record review, observation and interview; the facility failed to ensure 10 of 17 hazardous areas such as fuel fired heater rooms have a corridor door with a 3/4-hour fire protection rating. This deficient practice could</p>	K010029	<p>smoke barrier doors for proper closing and that each door is equipped with an astragal, rabbet or bevel at the meeting edge.</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b> Maintenance Director or designee will complete visual observation of smoke barrier doors to determine that they close without failure. Preventative maintenance will be completed as necessary. Results of the monthly observation will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p><b>V. Plan of Correction completion date.</b> Plan of Completion date is April 13, 2014.</p> <p><b>K 29</b></p> <p><b>I. The corrective actions to be accomplished for those</b></p>	04/13/2014			

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	<p>affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of facility blueprint documentation with the Maintenance Director during record review from 8:55 a.m. to 11:30 a.m. on 03/14/14, the fire resistance rating of hazardous area doors could not be determined. Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 3:10 p.m. on 03/14/14, the following areas each had a natural gas fired furnace or water heater in the room and the entry door from the corridor had no fire resistance rating label affixed to the door:</p> <p>a. mechanical rooms by the workroom by the Main Lobby, by the Conference Room, by the entrance to Assisted Living, by Room 814 and the Riser Room.</p> <p>b. the set of double doors to the mechanical rooms by Room 504, by Room 518, by Room 704, by Room 727, and by Room 809.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged each of the aforementioned hazardous areas entry room doors had no fire resistance rating label affixed to the door or available for review.</p>		<p><b>residents found to have been affected by the deficient practice.</b></p> <p>The 10 doors identified have been ordered with a ¾ hour fire protection rating door and installation has been scheduled.</p> <p>Self-closing devices have been ordered for the 2 doors that were identified and installation has been scheduled.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>All residents could potentially be affected.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not</b></p>				

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 17 hazardous areas such as fuel fired heater rooms are equipped with self closing doors which latch into the door frame. This deficient practice could affect 22 residents, staff and visitors in the 800 Hall.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 3:10 p.m. on 03/14/14, the mechanical room by Room 814 and the Environmental Services Office each contained one natural gas fired water heater and the corridor door was not equipped with a self closing device. Based on interview at the time of the observations, the Maintenance Director acknowledged the entry doors to the aforementioned hazardous areas were not equipped with a self closing device to self close and latch into the door frame.</p> <p>3.1-19(b)</p>				<p><b>recur.</b></p> <p>Doors installed in hazardous areas will have a 3/4 hour fire-rated door. Doors will be self-closing or have an automatic closer that will allow the door to latch into the door frame. Doors will be approved by Director of Facilities prior to installation.</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>Results of the purchases will be reviewed at the Quality Assurance Committee meeting the month following the inspection, frequency and duration of reviews will be adjusted as needed.</p> <p><b>V. Plan of Correction completion date.</b></p>		

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K010046 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1</p> <p>Based on record review, observation, and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 2 of 2 battery operated emergency lights. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted at 30 day intervals for at least 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Emergency Lights-Test Log for Year 2013 and 2014" documentation with the</p>	K010046	<p>Plan of Completion date is April 13, 2014.</p> <p><b>K 46</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>The battery operated lights have been tested to meet this requirement.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>All residents have the potential to be affected.</p>	04/13/2014

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	<p>Maintenance Director during record review from 8:55 a.m. to 11:30 a.m. on 03/14/14, the facility has two battery operated lights each located in Room 1007 which is the Main Electrical Room. The most recent documented annual functional testing of facility battery operated emergency lights was in January 2013 which was more than twelve months. In addition, documentation of monthly testing of the second battery operated light in the Main Electrical Room after May 2013 was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 3:10 p.m. on 03/14/14, two battery operated lighting systems were observed in the Main Electrical Room and each light functioned when their respective test button was pushed. Based on interview at the time of record review and of the observations, the Maintenance Director acknowledged monthly and annual functional testing documentation for all battery operated emergency lights in the facility was not available for review.</p> <p>3.1-19(b)</p>		<p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>The Director of Maintenance has been re-educated by the HFA on the Life Safety Requirement related to testing on battery operated lights and separate documentation must be kept on each battery operated light.</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>The Director of Maintenance will perform audits of battery operated lights monthly for 6 months.</p>		

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K010062 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review, observation and interview; the facility failed to ensure 3 of 3 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be</p>	K010062	<p>Results of the monthly testing will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is April 13, 2014.</p> <p><b>K 62 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b> There were no residents directly affected. Fire Hydrants have been inspected.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> All residents could potentially be affected. <b>III. The facility will put into place the following systematic changes to ensure</b></p>	04/13/2014

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	<p>inspected, and the necessary corrective action shall be taken. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 8:55 a.m. to 11:30 a.m. on 03/14/14, documentation of annual fire hydrant testing for facility fire hydrants within the last twelve months was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 3:10 p.m. on 03/14/14, three fire hydrants were located outside the facility near the front and rear parking lots. Based on interview at the time of record review and of the observations, the Maintenance Director stated the aforementioned fire hydrants were owned by the facility and acknowledged documentation of annual fire hydrant testing within the last twelve months was not available for review.</p> <p>3.1-19(b)</p>		<p><b>that the deficient practice does not recur.</b> The Maintenance Director has been re-educated as to the required components of this regulations assuring that the inspections occur annually. Maintenance Director has scheduled annual inspection and will provide HFA with paperwork following inspection. <b>IV The facility will monitor the corrective action by implementing the following measures.</b> Results of the inspection will be reviewed at the Quality Assurance Committee meeting the month following the inspection, frequency and duration of reviews will be adjusted as needed. <b>V. Plan of Correction completion date.</b> Plan of Completion date is April 13, 2014.</p>		

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K010069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen range hood's fire extinguishing equipment was inspected and approved every 6 months by properly trained and qualified persons. LSC 9.2.3 refers to NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, in 8-2 requires the inspection and servicing of the fire extinguishing system and listed exhaust hoods containing a constant or fire actuated water system shall be made at least every 6 months by properly trained and qualified persons. NFPA 96, 8-2.1 requires all actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, and fire actuated dampers shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice could affect five kitchen staff and visitors.</p> <p>Findings include:</p>	K010069	<p><b>K 69</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>There were no residents directly affected. Range hood fire extinguishing inspections were conducted in March and October 2013, however were greater than 6 months apart. Range Hood fire extinguishing inspection has been scheduled for April 2014 and October 2014.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p>	04/13/2014
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	<p>Based on review of Koorsen Fire &amp; Security "Restaurant Systems Work Order" documentation with the Maintenance Director during record review from 8:55 a.m. to 11:30 a.m. on 03/14/14, it had been greater than six months between the two most recent documented kitchen range hood fire extinguishing equipment inspections. Documentation indicated the two most recent kitchen range hood fire extinguishing equipment inspections were performed on 03/05/13 and 10/22/13. Based on interview at the time of record review, the Maintenance Director acknowledged it had been greater than six months in between the two most recent documented kitchen range hood fire extinguishing equipment inspections.</p> <p>3.1-19(b)</p>		<p>Kitchen associates could potentially be affected.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>The Maintenance Director has been re-educated as to the required components of this regulations assuring that the inspections occur every 6 months and paperwork maintained. Maintenance Director has scheduled 6 month inspections and will provide HFA with paperwork following inspection.</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p>				

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K010070 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 18.7.8</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 1 portable space heaters was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice affects two staff and visitors in the Maintenance Office.</p> <p>Findings include:</p>	K010070	<p>Results of the inspections will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is April 13, 2014.</p> <p><b>K 70</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p>	04/13/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155793	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  03/14/2014
NAME OF PROVIDER OR SUPPLIER  HAMILTON TRACE OF FISHERS			STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037		
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	<p>Based on review of "Portable Space Heaters" facility policy documentation with the Maintenance Director during record review from 8:55 a.m. to 11:30 a.m. on 03/14/14, portable space heating devices are permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 F. Based on observation with the Maintenance Director during a tour of the facility from 11:30 a.m. to 3:10 p.m. on 03/14/14, one "Weather Works" electric portable space heater was observed plugged into a wall outlet in the Maintenance Office. No documentation was affixed to the aforementioned portable space heater stating its operating temperature. Based on interview at the time of record review and observation, the Maintenance Director stated documentation of the operating temperature was not available for review and acknowledged the facility failed to ensure the portable space heater was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F).</p> <p>3.1-19(b)</p>		<p>Space heater has been removed from community. There were no residents affected.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>Residents residing at the facility have the potential to be affected, however none were identified.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>The Director of Maintenance has been re-educated on the life safety requirement of space heaters in skilled nursing facilities.</p>		

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			<p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>Administrator or designee will audit by observation monthly to ensure space heaters in office areas meet the regulatory requirement. Results of the observations will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is April 13, 2014.</p>	

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K010147 SS=C	<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 record review and interview, the facility failed to ensure extension cords including power strips would not be used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Power Strips" facility policy documentation with the Maintenance Director during record review from 8:55 a.m. to 11:30 a.m. on 03/14/14, power strips are permitted to be used in resident living areas. The aforementioned policy stated "only authorized power strips will be permitted in resident living areas to assure residents and staff adhere to safe practices." Based on interview at the time of record review, the Maintenance Director acknowledged the facility's power strip policy did not prohibit the use of extension cords and power strips in resident living areas to ensure they would not be used as a substitute for</p>	K010147	<p><b>K 147</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Power strip policy was updated.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>Residents utilizing a power strip could potentially be affected.</p> <p><b>III. The facility will put into</b></p>	04/13/2014			

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	fixed wiring.  3.1-19(b)		<p><b>place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>The Director of Maintenance has updated the policy. All residents and/or responsible parties have received a copy of the new policy regarding power strips.</p> <p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>Administrator or designee will audit by observation monthly to ensure power strips meet the regulatory requirement. Results of the observations will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p>		

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K010211 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> <li>o The corridor is at least 6 feet wide</li> <li>o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)</li> <li>o The dispensers shall have a minimum spacing of 4 ft from each other</li> <li>o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.</li> <li>o Dispensers are not installed over or adjacent to an ignition source.</li> <li>o If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623</li> </ul> <p>Based on observation and interview, the facility failed to ensure 6 of over 100 alcohol based hand sanitizers were not installed adjacent to an ignition source. NFPA 101, in 18.1.1.3 requires all health facilities to be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 50 residents, staff and visitors.</p>	K010211	<p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is April 13, 2014.</p> <p><b>K 211</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p>	04/13/2014			

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	<p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 3:10 p.m. on 03/14/14, the following alcohol based hand sanitizer's were observed installed adjacent to an ignition source:</p> <p>a. a hand sanitizer containing propylene glycol was installed within one inch of an electrical outlet in the men's restroom in the service corridor and within three inches of an electrical outlet in the men's and women's restrooms near the main entrance lobby.</p> <p>b. a hand sanitizer containing ethyl alcohol was installed above a light switch in the Soiled Laundry room and within three inches of a light switch in the Clean Laundry room.</p> <p>c. a hand sanitizer containing ethanol was installed above a light switch in the Taste of the Town Dining Room.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned hand sanitizer locations were alcohol based and were installed adjacent to an ignition source.</p> <p>3.1-19(b)</p>		<p>Hand sanitizers have been relocated.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>50 residents had the potential to be affected.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>Hand sanitizers will not be installed adjacent to an ignition source. Hand sanitizers placement will be approved by Director of Facilities prior to installation.</p>				

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			<p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>Administrator or designee will observe location of sanitizers following installation to ensure they meet the regulatory requirement. Results of the observations will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is April 13, 2014.</p>		