

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/26/2013
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NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077
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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: 12/26/13</p> <p>Facility Number: 000538 Provider Number: 155620 AIM Number: 100267290</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Zionsville Meadows 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 is a split level facility with each of the two floors exiting at ground level and was determined to be of Type II (000) construction and fully sprinklered except for the Environmental Services Office</p>	K010000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 plan of correction be considered as the letter of 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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	<p>closet. 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 detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 185 and had a census of 101 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except the Environmental Services Office closet and one detached building providing facility storage services.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/06/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010017 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 open use areas were separated from the corridor, or met an Exception. LSC 19.3.6.1, Exception # 1 Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke</p>	K010017	<p>1. A positive latching device has been added to the double doors leading into the Villa Dining Room.2. This deficient practice had the potential of affecting 10 residents. An audit was completed of all doors leading into corridors to ensure all doors were equipped with positive latching devices. Positive latching devices were added to all doors identified through the audit as needing them.3. Maintenance Supervisor or designee will audit all appropriate doors for the placement and functioning of positive latching devices as part of the Monthly Preventative Maintenance program.4. All</p>	01/25/2014

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	<p>detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice affects 10 residents, staff and visitors in the Activity Room in the vicinity of the Villa Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 4:10 p.m. on 12/26/13, the assisted living Villa Dining Room by the Activity Room was open to the corridor because each set of two doors to the dining room were not equipped with a positive latching device to latch each door into the door frame. Furthermore, Exception # 1, requirement (c) of the Life Safety Code, Chapter 19.3.6.1 was not met as follows: the Villa Dining Room open area was not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. Based on interview at the time of observation, the Maintenance Director stated skilled unit residents have access to the Activity Room which is in the same smoke compartment as</p>		<p>concerns identified through the Monthly Preventative Maintenance program will have immediate corrective action. Findings from the monthly audits will be reviewed at the Monthly Continued Quality Improvement meeting to identify possible trends and effectiveness of corrective actions.</p>				

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K010018 SS=E	<p>the Villa Dining Room and acknowledged the Villa Dining Room was not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station.</p> <p>3.1-19(b)</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> <p>1. Based on observation and interview, the facility failed to provide 9 of over 150 corridor doors with a positive latching device. This deficient practice could affect 72 residents, staff and visitors.</p>	K010018	<p>1. Positive latching devices were added to the entrance doors to the kitchen from the service hall, all corridor doors leading into the Villa Dining Room, the three kitchen doors leading into the Villa Dining Room, the 300 hall soiled utility room, and the 300 hall clean utility room. The kick</p>	01/25/2014	

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	<p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 4:10 p.m. on 12/26/13, the following was noted:</p> <p>a. the entrance to the kitchen from the service corridor is a double door set and each door was not equipped with a positive latching mechanism to latch the door set into the door frame.</p> <p>b. two of two corridor doors to the the assisted living Villa Dining Room were not equipped with a positive latching device to latch each door into the door frame.</p> <p>c. three kitchen doors to the assisted living Villa Dining Room were not equipped with a positive latching device to latch each door into the door frame.</p> <p>d. the 300 Hall soiled utility room and the 300 Hall clean utility room were each not equipped with a positive latching device to latch each door into the door frame.</p> <p>Based on interview at the time of the observations, the Maintenance Director stated skilled unit residents have access to the Activity Room which is in the same smoke compartment as the Villa Dining Room and acknowledged the aforementioned corridor doors were not provided with a positive latching device.</p>		<p>down door stops were removed from the kitchen doors leading into the service hall.2. This deficient practice had the possibility of affecting 72 residents. An audit was completed of all doors leading into corridors to ensure all doors were equipped with positive latching devices. Positive latching devices were added to all doors identified through the audit as needing them. An audit was also conducted to ensure there were no impediments to the closing of corridor doors. All noted impediments were removed. 3. Maintenance Supervisor or designee will audit all appropriate doors for the placement and functioning of positive latching devices as part of the Monthly Preventative Maintenance program. Maintenance Director or designee will do daily walk through of the facility to ensure there are no impediments in place to prevent the closing of corridor doors. 4. All concerns identified through daily rounds and the Monthly Preventative Maintenance program will have immediate corrective action. Findings from the monthly audits will be reviewed at the Monthly Continued Quality Improvement meeting to identify possible trends and effectiveness of corrective actions.</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 over 150 corridor doors did not have an impediment to closing and latching. This deficient practice could affect 20 residents, staff and visitors if needing to exit the facility from the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 4:10 p.m. on 12/26/13, the entrance to the kitchen from the service corridor is a double door set and each door was observed held open with an attached kick down door stop. Based on interview at the time of observation, the Maintenance Director acknowledged the service corridor door set to the kitchen had an impediment to closing and latching.</p> <p>3.1-19(b)</p>				

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K010029 SS=E	<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>1. Based on observation and interview, the facility failed to ensure 4 of 4 mobile soiled linen carts were stored in areas separated from other spaces by smoke resistant partitions and doors. This deficient practice could affect 20 residents, staff and visitors if needing to exit the facility by the service corridor.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director at 9:10 a.m., between 11:50 a.m. and 4:10 p.m. on 12/26/13, two unattended 32 gallon soiled linen carts and two 16 cubic foot (119 gallons) capacity soiled linen carts were unattended and stored next to each other in the service corridor which was marked as a facility exit by the Activity Room. Based on interview at the time of the observations, the Maintenance</p>	K010029	<p>1. All four identified soiled linen carts have been separated and are now stored in separate spaces separated by smoke resistant partitions and doors. Self closing and positive latching devices were added to the double doors leading to the Central Supply Room. A new self closing device was added to the 300 Hall Soiled Linen Room. A self closing device was added to the 300 Hall Housekeeping Room2. An audit was completed of all facility doors to ensure that all appropriate doors are equipped with fully functioning self closing devices. Housekeeping supervisor has designated appropriate storage areas for all mobile soiled linen and trash containers.3. Maintenance Supervisor or designee will audit all self closing devices for proper installation and functioning as part of the Monthly Preventative Maintenance Program.</p>	01/25/2014	

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	<p>Director acknowledged unattended mobile trash carts with capacity of greater than 32 gallons capacity were not stored in areas separated from other spaces by smoke resistant partitions and doors.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure ensure 3 of 10 hazardous areas such as fuel fired heater rooms, soiled linen rooms and storage rooms greater than fifty square feet in area for combustibles storage were separated from other spaces by smoke resistant partitions and equipped with self closing devices on entry room doors which latched securely into their door frames. This deficient practice could affect 62 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 4:10 p.m. on 12/26/13, the following was noted:</p> <p>a. the double door set at the entrance to the Central Supply Room by the loading dock was not equipped with a positive latching device on each door to latch the door set into the door frame. In</p>		<p>Appropriate corrective action will be implemented immediately for all noted concerns. Housekeeping Supervisor or designee will do daily audits to ensure all mobile trash and linen carts are stored in appropriate areas. Appropriate corrective action will be implemented immediately for all noted concerns. 4. Findings from all audits will be reviewed at monthly Continued Quality Improvement meeting by Interdisciplinary Team in order to determine effectiveness of corrective action and to identify trends.</p>				

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K010038 SS=E	<p>addition, the aforementioned door set was not equipped with self closing devices. One natural gas fired boiler was observed in operation in the Central Supply Room.</p> <p>b. the door to the 300 Hall soiled linen room had a broken self closing device which did not allow the entry room door to self close.</p> <p>c. the 300 Hall Housekeeping Room measured 200 square feet in area, was used to store combustible boxes and the entry door was not equipped with a self closing device.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned doors were not provided with self closing devices and positive latching mechanisms.</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>1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 delayed egress locks in the facility was readily</p>	K010038	<p>1. The delayed egress for the door exiting the Chrystal Dining room has been repaired and now functions correctly. The code for the magnetic lock has been</p>	01/25/2014
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	accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor 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 the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads:		posted for the door exiting the service corridor.2. An audit of all exits to ensure delayed egress systems function correctly and that on doors with magnetic locking systems codes are posted when appropriate. Corrective actions were implemented for any findings from the audits.3. The Director of Maintenance or designee will audit all delayed egress systems on facility exit doors weekly as part of the Weekly Preventative Maintenance Program. The Director of Maintenance or designee will audit to ensure the posting of codes for magnetic locks monthly as part of the Monthly Preventative Maintenance Program. 4. Findings from all audits will be reviewed at monthly Continued Quality Improvement meeting by Interdisciplinary Team in order to determine effectiveness of corrective action and to identify trends.		

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	<p>PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS.</p> <p>This deficient practice could affect 60 residents, staff or visitors if needing to exit the facility using the Crystal Dining Room exit by the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 4:10 p.m. on 12/26/13, the Crystal Dining Room exit by the service corridor is marked as a facility exit, is equipped with a delayed egress lock and provided with signage stating the door could be opened in 15 seconds by pushing on the door release device but the exit door did not release when the door was pushed with the application of force for 15 seconds five separate times. Based on interview at the time of observation, the Maintenance Director stated the Crystal Dining Room exit by the service corridor is a facility exit, the exit door is equipped with a delayed egress lock and acknowledged the exit door did not release when the door was pushed with the application of force for 15 seconds five separate times.</p> <p>3.1-19(b)</p>			

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	<p>2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 2 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect 20 residents, staff and visitors if needing to exit the facility from the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 4:10 p.m. on 12/26/13, the entrance to the service corridor by the Activity Room is marked as a facility exit and was unlocked. The service corridor exit door to the loading dock area is also marked as a facility exit and was magnetically locked and</p>						

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	could be opened by entering a four digit code but the code was not posted. Based on interview at the time of observation, the Maintenance Director stated residents with a clinical diagnosis requiring specialized security measures are housed in a separate portion of the facility on the lower level and acknowledged the four digit code was not posted at the service corridor exit. 3.1-19(b)						
K010045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 Based on observation and interview, the facility failed to ensure lighting for 1 of 16 exit means of egress, including exit discharge, was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect 28 residents, staff and visitors if needing to exit the facility from Exit 3 by Room	K010045	1. The light bulb was replaced in the light fixture outside of Exit 3. There are now two working light fixtures at Exit 3.2. An audit of all the facility's means of egress was completed to ensure that appropriate illumination was present and that the failure of a single bulb would not leave the egress in darkness. Corrective action was immediately	01/25/2014			

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K010046 SS=C	<p>116.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 4:10 p.m. on 12/26/13, the exit discharge for Exit 3 by Room 116 to the outside of the building was equipped with two separate lighting fixtures with one bulb per fixture. The light fixture directly above the Exit 3 door set on the outside of the building did not contain a light bulb leaving the area lighted with one light fixture and one bulb. No other exit discharge lighting fixtures for Exit 3 were noted. Based on interview at the time of observation, the Maintenance Director acknowledged only one bulb was provided at the exit means of egress from Exit 3 by Room 116.</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. Based on record review, observation and</p>	K010046	<p>implemented for any findings from the audit.3. Maintenance Director or designee will audit illumination of all facility egresses monthly as part of the Monthly Preventative Maintenance Program. Corrective action for any findings will be immediately implemented upon completion of the audit. 4. Findings from all audits will be reviewed at monthly Continued Quality Improvement meeting by Interdisciplinary Team in order to determine effectiveness of corrective action and to identify trends.</p> <p>1. A ninety minute functioning test was conducted for the facility</p>	01/25/2014			

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	<p>interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 2 of 2 battery powered lights for 12 months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 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 in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:20 a.m. to 11:50 a.m. on 12/26/13, documentation of an annual ninety minute test for battery operated emergency lights in the facility was not available for review. In addition, functional testing documentation for battery operated emergency lights in the facility at 30 day intervals for not less than 30 seconds for the most recent twelve month period</p>		<p>emergency lighting systems. All lighting functioned correctly. A 30 second functioning test of the battery back up lighting was conducted and both lights functioned correctly.2. The Director of Maintenance or designee will conduct and document monthly tests of battery back up lighting systems. The Director of Maintenance or designee will also conduct an annual 90 minute functioning test of all emergency lighting. 3. The monthly test of the battery back up lighting systems will be scheduled as part of the Monthly Preventative Maintenance Program. The 90 minute functioning test of all emergency lighting will be scheduled for every June as part of the Facility Preventative Maintenance Program. 4. Findings from all test will be reviewed at monthly Continued Quality Improvement meeting by Interdisciplinary Team in order to determine effectiveness of corrective action and to identify trends.</p>				

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	<p>was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 4:10 p.m. on 12/26/13, one battery operated emergency light was located in the Cottage 2 lower level lobby and one battery operated emergency light was located outside the facility at the emergency generator location. Each of the aforementioned lights operated when their respective test button was pushed. Based on interview at the time of record review and at the time of the observations, the Maintenance Director acknowledged documentation of an annual ninety minute test and monthly functional testing documentation for the most recent twelve month period for each of the aforementioned two battery operated emergency lights was not available for review.</p> <p>3.1-19(b)</p>			

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K010050 SS=F	<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>Based on record review and interview, the facility failed to document fire drills conducted on the first, second and third shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Report" documentation during record review with the Maintenance Director from 9:20 a.m. to 11:50 a.m. on 12/26/13, documentation of a fire drill conducted on the third shift in the fourth quarter of 2012 (October, November, December), on the first shift in the first quarter of 2013 (January, February, March) and on the second shift in the second quarter of 2013 (April, May, June) was not available for review. Based on interview at the time of record review, the Maintenance Director</p>	K010050	<p>1. An annual schedule for all fire drill has been developed to ensure that a drill is held on each shift a minimum of quarterly at varying times. Facility has implemented this schedule starting January 2014. Facility will complete and document fire drills according to the developed schedule.3. Executive Director will review all fire drill documentation monthly to ensure that drills are being conducted according to schedule and held a minimum of quarterly on every shift at varying times.4. Outcomes of the monthly fire drills will be reviewed at the Monthly Continued Quality Improvement meeting. Corrective action for any identified concerns or trends will be implemented immediately.</p>	01/25/2014	

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K010056 SS=B	<p>acknowledged documentation of a fire drill conducted for the aforementioned shifts and calendar quarters in 2012 and 2013 was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure a sprinkler was installed in 1 of 1 Environmental Services Office's closets to provide coverage for all portions of the building. This deficient practice could affect 10 staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K010056	<p>1. The closet in the environmental services office has been removed and the bulkhead cut out. This leaves an open space that is protected by the sprinkler heads already installed in the office. With the removal of the closet and bulkhead an additional sprinkler head is not warranted. 2. An audit was conducted to ensure that sprinklers are present in all closets and overhangs required to have sprinklers. No other</p>	01/25/2014

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K010064 SS=E	<p>Maintenance Director during a tour of the facility from 11:50 a.m. to 4:10 p.m. on 12/26/13, the Environmental Services Office closet was not sprinklered. Based on interview at the time of observation, the Maintenance Director acknowledged the Environmental Services Office closet was not sprinklered.</p> <p>3.1-19(b) 3.1-19(ff)</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 facility failed to inspect 2 of 29 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable</p>	K010064	<p>findings were noted.3 Sprinklers will be added to any area all closets and overhangs requiring sprinklers should they be constructed in the future.</p> <p>1. Both the fire extinguisher in the Laundry room and the fire extinguisher in the elevator mechanical room have been inspected and tags dated for January 2014.2. Both of these fire extinguishers have been added to the list of extinguishers to be inspected monthly. An audit was conducted of all facility fire extinguishers to ensure that all others had been inspected monthly.3. The Director of Maintenance or designee will inspect all fire extinguishers monthly and record inspections</p>	01/25/2014

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	<p>assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect 26 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 4:10 p.m. on 12/26/13, the maintenance tag attached to the portable fire extinguisher located in the washing machine area of the Laundry and the maintenance tag attached to the portable fire extinguisher located in the elevator machine room in Cottage 2 each indicated a monthly inspection was not documented for the eight month period of March 2013 through November 2013. Based on interview at the time of the observations, the Maintenance Director stated no other monthly fire extinguisher inspection documentation was available for review and acknowledged a monthly inspection for the aforementioned portable fire extinguisher locations was not documented for March 2013 through November 2013.</p>		<p>on the extinguisher tag as part of the Monthly Preventative Maintenance Program.4. The Executive Director of designee will inspect all extinguisher tags at the end of each month to ensure that monthly inspections have been completed.</p>				

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K010066 SS=A	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container with a self closing lid at 1 of 2 outside areas where smoking was permitted. This deficient practice could affect five staff.</p>	K010066	1. A noncombustible ashtray and a noncombustible container with a self closing lid have been added to all entrances so that staff and visitors may dispose of cigarette butts appropriately. Staff wishing to smoke on their breaks must now go to their vehicles to do so. There is no other designated employee	01/25/2014	

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 4:10 p.m. on 12/26/13, the staff smoking area located ten feet outside of the building at the bay to the loading dock near the parking lot and at the emergency generator had in excess of 200 extinguished cigarette butts deposited on the ground. A noncombustible ash tray and a metal container with a self closing cover device into which ashtrays can be emptied were not provided in this area where staff smoking was taking place. Based on interview at the time of observation, the Maintenance Director acknowledged cigarette butts were disposed on the ground by staff and a noncombustible ash tray and metal container with a self closing cover device into which ashtrays can be emptied were not provided at the aforementioned outside smoking area.</p> <p>3.1-19(b)</p>		<p>smoking area other than their personal vehicles at this time.2. Housekeeping supervisor or designee will audit all facility entrances to ensure cigarette butts are appropriately disposed of and that noncombustible ashtray and container are emptied appropriately.</p>				

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K010069 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1999 edition, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect five staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on review of 360 Services "Fire Protection Service Report" documentation dated 04/18/13 during record review with the Maintenance Director from 9:20 a.m. to 11:50 a.m. on 12/26/13, documentation of a semiannual hood extinguishing systems inspection after 04/18/13 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of a semiannual hood extinguishing systems inspection after 04/18/13 was not available for review.</p>	K010069	<p>1. Facility hood system was inspected on December 31, 2013. 360 Services also evaluated what needed to be done to correct the electrical shut off. 2. 360 Services has been contracted to make the needed repairs to electrical shut off of gas range and items under the hood system.3. Upon completion of the repairs the electrical shut offs will be checked for proper functioning. 4. The hood system and functioning of electrical shutoff will be tested semi-annually per contract with inspection vendor. Inspection reports will be brought to and reviewed at the following Continued Quality Improvement meeting. Corrective action will be implemented immediately for any findings from the inspections.</p>	01/25/2014
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	<p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 gas fired ranges in the kitchen was equipped with a functional shut off. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1999 edition, Section 7-4.1 states upon activation of any fire extinguishing system for a cooking operation, all sources of fuel and electric power that produce heat to all equipment requiring protection by that system shall automatically shut off. This deficient practice could affect five staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on review of 360 Services "Fire Protection Service Report" documentation dated 02/15/13 and 04/18/13 during record review with the Maintenance Director from 9:20 a.m. to 11:50 a.m. on 12/26/13, the gas fired range in the kitchen is not equipped with a functional shut off. The "Additional Comments" section of the 02/15/13 service report stated "Red tagged no electric shut off" and the 04/18/13 service report stated "Electric still inoperable." Based on interview at the</p>						

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K010070 SS=B	<p>time of record review, the Maintenance Director stated an electrical relay for the kitchen range shut off has not been repaired and is inoperable and acknowledged the gas fired range in the kitchen is not equipped with a functional shut off.</p> <p>3.1-19(b)</p> <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) 19.7.8</p> <p>Based on record review, observation and interview; the facility failed to ensure the heating elements in 1 of 1 portable space heating devices used in nonsleeping staff and employee areas do not exceed 212 F. This deficient practice could affect 10 staff and visitors in the vicinity of the Maintenance Office.</p> <p>Findings include:</p> <p>Based on review of "Disaster Action</p>	K010070	<p>1. The electric space heater has been removed from the Maintenance office.2. An audit of all facility rooms was conducted to ensure no space heaters were in use anywhere in the building. No other units were found.3. All staff were re-educated on the fact that the use of space heaters within the facility is prohibited.4. The Director of Maintenance or designee will do weekly rounds of facility rooms and offices to ensure space heaters not being utilized. If space heaters are found they will be immediately removed and placed in the</p>	01/25/2014
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	<p>Plan - Fire Prevention Policy" documentation during record review with the Maintenance Director from 9:20 a.m. to 11:50 a.m. on 12/26/13, Section 9.6 states, "Space heaters may not be used in any area of the facility." Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 4:10 p.m. on 12/26/13, an electric space heater was plugged into a power strip which was plugged into an extension cord in the Maintenance Office. Based on interview at the time of observation, the Maintenance Director stated documentation of the heating element's maximum temperature rating in the aforementioned portable space heating device was not available for review and acknowledged a portable space heater was in use in the Maintenance Office.</p> <p>3.1-19(b)</p>		Executive Director's office.		

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K010072 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure 1 of 16 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director at 9:10 a.m., 11:50 a.m. and at 4:10 p.m. on 12/26/13, the service corridor entrance by the Activity Room is marked as a facility exit and two 32 gallon soiled linen carts, two 16 cubic foot capacity soiled linen carts and two five foot long by five foot high by two foot wide clothes racks with donated clothes stored on hangers were stored in the service corridor. Each of the 16 cubic foot capacity soiled linen carts extended five feet from the wall into the corridor and was placed in the means of egress for the service corridor. Based on interview at the time of the</p>	K010072	<p>1. The 32 gallon soiled utility carts, clothes racks, and 16 cubic foot soiled linen carts have been removed from the service hall and are now stored in appropriate rooms.2. All staff have been re-educated on the need to keep the service hall egress free of impediment.3. Housekeeping supervisor will conduct daily rounds to ensure that the service hall egress stays free of impediments.</p>	01/25/2014			

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K010074 SS=E	<p>observations, the Maintenance Director acknowledged the service corridor is marked as a facility exit and was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>3.1-19(b)</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>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 record review, observation and interview; the facility failed to ensure</p>	K010074	1. All of the identified window curtains have been treated with flame retardant. A log has been	01/25/2014	

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	<p>window curtains in resident sleeping rooms in 2 of 12 smoke compartments were flame resistant. This deficient practice could affect 52 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 4:10 p.m. on 12/26/13, window curtains in resident sleeping Room 101, 103, 104, 105, 106, 108, 110, 112, 114, 116, 118, 120, 121, 123, 124, 126, 128, 130, 132, 134, 136, 138, 140, 142 and 144 had no affixed documentation stating each curtain was inherently flame retardant. Based on record review with the Maintenance Director from 9:20 a.m. to 11:50 a.m. on 12/26/13, resident room window curtain flame resistance documentation was not available for review. Based on interview at the time of the observations, the Maintenance Director stated he was unaware if resident room curtains are treated with a flame retardant material and acknowledged resident room window curtain flame resistance documentation for the aforementioned resident sleeping rooms was not available for review.</p> <p>3.1-19(b)</p>		<p>created to ensure that appropriate and timely treatments of the materials are completed.2. An audit was conducted of all window treatments and privacy curtains to ensure that all have proper flame retardant documentation. All those identified as not having proper labels were treated with flame retardant.3. The schedule for flame retardant treatments has been added to the preventative maintenance schedule.4. Completion of flame retardant treatments will be reviewed at Monthly Continued Quality Improvement Meeting. Corrective action for all noted concerns will be implemented immediately .</p>		

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K010075 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for mobile soiled linen or trash collection receptacles was not exceeded within any 64 square feet area in 1 of 16 corridors and mobile soiled linen receptacles greater than 32 gallons were located in a room protected as a hazardous area when not attended. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director at 9:10 a.m., 11:50 a.m. and at 4:10 p.m. on 12/26/13, two 32 gallon soiled linen carts and two 16 cubic foot (119 gallons) capacity soiled linen carts were stored next to each other in the service corridor. Based on interview at the time of the</p>	K010075	<p>All four identified soiled linen carts have been separated and are now stored in separate spaces separated by smoke resistant partitions and doors. Housekeeping supervisor has designated appropriate storage areas for all mobile soiled linen and trash containers. Housekeeping Supervisor or designee will do daily audits to ensure all mobile trash and linen carts are stored in appropriate areas. Appropriate corrective action will be implemented immediately for all noted concerns. 4. Findings from all audits will be reviewed at monthly Continued Quality Improvement meeting by Interdisciplinary Team in order to determine effectiveness of corrective action and to identify trends.</p>	01/25/2014
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K010076 SS=E	<p>observations, the Maintenance Director acknowledged mobile soiled linen receptacles greater than 32 gallons were not located in a room protected as a hazardous area when not attended and a capacity of 32 gallons for mobile soiled linen receptacles was exceeded within any 64 square foot area not located in a room protected as a hazardous area.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3,000 cubic feet are vented to the outside by a dedicated mechanical ventilation system or by natural venting. If natural venting is used, the vent opening or openings shall be a minimum of 72 square inches</p>	K010076	<p>1. A working mechanical vent fan has been added to the 300 hall oxygen room This is the only oxygen storage room in the facility Director of Maintenance or designee will check functioning of mechanical vent fan weekly as part of the Preventative Maintenance Program. Corrective actions will</p>	01/25/2014
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	<p>in total free area. This deficient practice could affect 42 residents, staff and visitors in the vicinity of the 300 Hall oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 4:10 p.m. on 12/26/13, the 300 Hall oxygen storage and transfilling room which was used to store ten liquid oxygen containers was not provided with continuous mechanical ventilation. A mechanical vent was observed in place on the ceiling in the room, but the mechanical vent was inoperable. Based on interview at the time of observation, the Maintenance Director acknowledged the 300 Hall oxygen storage room was not provided with continuous mechanical ventilation or with natural vent openings of greater than 72 square inches in total free area.</p> <p>3.1-19(b)</p>		<p>be implemented immediately for any issues found on weekly checks.Preventative Maintenance program audits will be reviewed at Monthly Continued Quality Improvement Meeting.</p>		

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K010143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage and transfilling rooms was provided with continuous mechanical ventilation. This deficient practice could affect 42 residents, staff and visitors in the vicinity of the 300 Hall oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 4:10 p.m. on 12/26/13, the 300 Hall oxygen storage and transfilling room which was used to store ten liquid oxygen containers was not provided with</p>	K010143	<p>1. A working mechanical vent fan has been added to the 300 hall oxygen room. This is the only oxygen storage room in the facility. Director of Maintenance or designee will check functioning of mechanical vent fan weekly as part of the Preventative Maintenance Program. Corrective actions will be implemented immediately for any issues found on weekly checks. Preventative Maintenance program audits will be reviewed at Monthly Continued Quality Improvement Meeting.</p>	01/25/2014	

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K010144 SS=F	<p>continuous mechanical ventilation. A mechanical vent was observed in place on the ceiling in the room, but the mechanical vent was inoperable. Based on interview at the time of observation, the Maintenance Director acknowledged the 300 Hall oxygen storage and transfilling room was not provided with continuous mechanical ventilation.</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.</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 11 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency</p>	K010144	<p>1. MacAllister Machinery Company (Generator Vendor) conducted an inspection of generator inspections on January 10, 2014. All areas were within normal limits. Director of Maintenance was re-educated on the proper formula for load testing and emergency transfer times. Director of Maintenance was also re-educated on the proper placement of documentation for load test and transfer times as part of the Preventative Maintenance Program. Director of Maintenance or designee will conduct and document monthly load tests at no less than 30% of</p>	01/25/2014

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	<p>electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator-Weekly Generator Inspection Checklist" and "Weekly Generator Inspection Sheet" documentation for 2012 and 2013 with the Maintenance Director during record review from 9:20 a.m. to 11:50 a.m. on 12/26/13, a one hour load test is conducted each week but load test documentation for the most recent 52 week period did not include if the emergency generator ran under operating temperature conditions, at not less than 30% of the EPS nameplate</p>		<p>Emergency Power Supply nameplate rating. Outcomes of Generator tests will be reviewed in the monthly Continued Quality Improvement meeting. Corrective action will be implemented immediately for all noted concerns from the tests.</p>				

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	<p>rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. A review of MacAllister Machinery's "Load Bank Test Report" dated 05/15/13 indicated the emergency generator ran under operating temperature conditions, at not less than 30% of the EPS nameplate rating for at least 30 minutes. Based on interview at the time of record review, the Maintenance Director acknowledged load test documentation for eleven of twelve months did not include if the emergency generator ran under operating temperature conditions, at not less than 30% of the EPS nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 11 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of</p>			

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	<p>normal power. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available 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 "Emergency Generator-Weekly Generator Inspection Checklist" and "Weekly Generator Inspection Sheet" documentation for 2012 and 2013 with the Maintenance Director during record review from 9:20 a.m. to 11:50 a.m. on 12/26/13, a one hour load test is conducted each week but load testing documentation for emergency power transfer time for the twelve month period of December 2012 through November 2013 was not available for review. A review of MacAllister Machinery's "Load Bank Test Report" dated 05/15/13 indicated emergency power transferred to the emergency generator within 10 seconds. Based on interview at the time of record review, the Maintenance Director stated no additional generator transfer time documentation for emergency power transfer time was available for review and acknowledged emergency power</p>				

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K010147 SS=B	<p>transfer time was not documented for eleven of twelve months.</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 Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not 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 ten staff and visitors in the vicinity of the Maintenance Office and the Environmental Services Office.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 4:10 p.m. on 12/26/13, the following was noted: a. a portable space heater was plugged into a power strip which was plugged into an extension cord in the</p>	K010147	<p>1. The space heater identified in the Maintenance room has been removed. The power strips have been removed from the Environmental office and all items identified are now plugged directly into the wall outlets.2. An audit was completed of all facility rooms and offices to ensure that inappropriate items were plugged into power strips and that power strips were not being used as substitute for fixed wiring. All concerns noted on the audit were corrected immediately3. Resident care coordinators will check their assigned rooms and offices daily to ensure that power strips and extension cords are not being utilized. 4. Findings from all audits will be reviewed at monthly Continued Quality Improvement meeting by Interdisciplinary Team in order to determine effectiveness of corrective action and to identify trends.</p>	01/25/2014

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	<p>Maintenance Office.</p> <p>b. a refrigerator, coffee pot and a microwave oven were plugged into a power strip in the Environmental Services Office.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged extension cords including power strips were in use as a substitute for fixed wiring at the aforementioned locations.</p> <p>3.1-19(b)</p>			