STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 04/29/2014
NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	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). Survey Date: 04/29/14 Facility Number: 000069 Provider Number: 155148 AIM Number: 100288980 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, North Park Nursing Center 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. This one story facility with a basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and in spaces open to the corridors, plus battery operated smoke	K010000	The facility would like to request paper compliance for this survey.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	detectors in all resident sleeping rooms. The facility has a capacity of 110 and had a census of 94 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except four detached wood framed sheds used for facility storage. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/05/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010018 SS=F	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 Roller latches are prohibited by CMS regulations in all health care facilities.			

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	1. Based on observation and interview, the facility failed to ensure there were no impediments to closing 10 of 56 resident room doors in 5 of 5 smoke compartments where resident room were located. This deficient practice could affect 18 residents in rooms, 112, 115, 119, 121, 124, 139, 143, 144, 155, and 165, plus other residents, staff, and visitors while in all resident room corridors. Findings include: Based on observations on 04/29/14 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with with the Maintenance Supervisor, resident rooms 112, 115, 119, 121, 124, 139, 143, 144, 155, and 165 were held open with small waste baskets. This was acknowledged by the Maintenance Supervisor at the time of each observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 Dutch doors was smoke resistant. NFPA 101 at 19.3.6.3.6 states Dutch doors shall be permitted as long as the meeting edges of the upper and lower leaves shall be equipped with an astragal, a rabbet, or a bevel. This deficient practice could	K010018	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?1.Spring hinges have been ordered for rooms 112, 115, 119, 121, 124, 139, 143, 144,155 and 165 door adjustments are being made so door work as they should and stay open and then close as required.2. Dutch door will be replaced with a standard fire rated door. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?All residents have the potental to be affected by the alleged deficient practice.Doors will be checked during a monthly preventive maintenance checks. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?1.Spring hinges have been ordered for rooms 112, 115, 119, 121, 124, 139, 143, 144,155 and 165 door adjustments are being made so door work as they should and stay open and then close as required.2. Dutch door will be replaced with a standard fire rated door. Dutch doors will no longer be used in the facility.How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?To ensure compliance the Maintenance	05/29/2014

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	affect 2 residents in room 168, plus all other residents, staff and visitors while in the D Hall corridor. Findings include: Based on observation on 04/29/14 at 1:15 p.m. during a tour of the facility with the Maintenance Supervisor, resident room 168 in the D Hall was equipped with a Dutch door that had a one half inch gap between the upper and lower leaves of the door without an astragal, a rabbet, or a bevel. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		Director/Designee will use a CQI audit tool to check 5 doors weekly for 4 weeks, then bi-monthly for 2 months then monthly there after for compliance. The results of these audits will be rewiewed by the CQI committee overseen by the ED.	
K010025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure smoke partitions, such as drop in ceiling tiles, were	K010025	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Tiles have	05/29/2014

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	provided to limit the transfer of smoke in 2 of 8 smoke compartments. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke. This deficient practice could affect mostly staff in the basement and up to 21 residents, staff and visitors while in the D Hall. Findings include: Based on observations on 04/29/14 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Maintenance Supervisor, there were ten ceiling tiles missing in the four basement rooms, and a half ceiling tile missing in the D Hall employee closet. This was acknowledged by the Maintenance Supervisor at the time of each observation. 3.1-19(b)		been replaced in the Basement, and in the employee closet that was sited. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potental to be affected by the alleged deficient practice. Tiles will be checked during a monthly preventive maintenance checks and as reported if need prior to monthly checks. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? Tiles will be checked during a monthly preventive maintenance checks and as reported if need prior to monthly checks. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?To ensure compliance the Maintenance Director/Designee will use a CQI audit tool to check 5 Tiles weekly for 4 weeks, then bi-monthly for 2 months then monthly there after for compliance. The results of these audits will be rewiewed by the CQI committee overseen by the ED.	
K010046 SS=C	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.			

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	Based on record review and interview, the facility failed to ensure 1 of 1 battery powered light sets was tested monthly for 30 seconds and annually for 90 minutes. LSC 101, Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. 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. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the Life Safety Code Documentation book on 04/29/14 at 10:45 a.m. with the Maintenance Supervisor present, there was no documentation to show the battery back up light set over the generator was tested monthly, furthermore, there was no documentation to show the battery back	K010046	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The generator was tested for a full load and was found to work as directed. Maintenance Director/Designee will ensure that generator is tested monthly and set up on a monthly PML schedule and the test will be logged when complete and any problems will be noted and immediatly addressed. Battery emergency Light will be tested and recorded that it has ran for at least 30 seconds and recorded with the generator checks. The emergency light will also be tested annualy for no less than 90 minutes and recorded on PML log as such. · How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potental to be affected by the alleged deficient practice. Maintenance Director/Designee will ensure that generator is tested monthly and set up on a monthly PML schedule and the test will be logged when completed and any problems will be noted and immediatly addressed. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? Maintenance Director/Designee will ensure that	05/29/2014

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	up light set was tested for ninety minutes annually within the past twelve months. This was confirmed by Maintenance Supervisor at the time of record review. 3-1.19(b)		generator is tested monthly and set up on a monthly PML schedule and the test will be logged when completed and any problems will be noted and immediatly addressed. Battery emergency Light will be tested and recorded that it has ran for at least 30 seconds and recorded with the generator checks. The emergency light will also be tested annualy for no less than 90 minutes and recorded on PML log as such. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance the Maintenance Director/Designee will use a CQI audit tool to check Generator and ememergency light 30 seconds and then 90 minutes (annualy) weekly for 4 weeks, then bi-monthly for 2 months then monthly there after for compliance. The results of these audits will be rewiewed by the CQI committee overseen by the ED. · · · · · · I	
K010048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 94 of 94 residents to accurately	K010048	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Disaster Manual has been updated with	05/29/2014

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	address all life safety systems such as the use of the K-class fire extinguisher in the kitchen or staff response to battery operated or single station smoke detectors in resident sleeping rooms. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the Fire Prevention plan in the Disaster Manual on 04/29/14 at 11:40 a.m. with the Maintenance Supervisor present, the Fire Prevention plan did not address the use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system or staff response to battery operated or single station smoke detectors in resident sleeping rooms. Based on interview at		the requirment written under LSC 19.7.2.2 for health care occupancy fire safety plan. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potental to be affected by the alleged deficient practice. Maintenance Director/Designee will ensure that Disaster Manual is reviewed monthly and set up on a monthly PML schedule so updates can be done as needed. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? Disaster Manual has been updated with the requirment written under LSC 19.7.2.2 for health care occupancy fire safety plan. Maintenance Director/Designee will ensure that Disaster Manual is reviewed monthly and set up on a monthly PML schedule so updates can be done as needed. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance the Maintenance Director/Designee will use a CQI audit tool to check Disaster Manual bi-monthly for 2 months then monthly there after for compliance. The results of these audits will be rewiewed by the	

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	the time of record review, the Maintenance Supervisor acknowledged the Fire Prevention plan did not include the previously mentioned items. 3.1-19(b)		CQI committee overseen by the ED.	
K010050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure complete information for 1 of 12 fire drills performed was provided on the fire drill form. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drills in the Life Safety Code Documentation book on 04/29/14 at 10:15 a.m. with the Maintenance Supervisor present, the second shift (evening) fire drill performed during the fourth quarter of 2013 on 11/26/13 was documented as a	K010050	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Fire Drills have been scheduled and will be done monthly. The Drills will be recorded monthly with the findings of the drills and any corrective actions required. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potental to be affected by the alleged deficient practice. Maintenance Director/Designee will ensure that Fire Drills are done monthly. The Drills will be recorded	05/29/2014

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	"silent drill" and did not include a time of day the drill was performed. During an interview at the time of record review, the Maintenance Supervisor acknowledged the 11/26/13 fire drill did not include the time of day the drill was performed. 3-1.19(b)		monthly with the findings of the drills and any corrective actions required. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? Maintenance Director/Designee will ensure that Fire Drills are done monthly. The Drills will be recorded monthly with the findings of the drills and any corrective actions required. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director/Designee will iniate Fire Drills monthly and record the findings on a fire drill log. The monthly Fire Drills will be reviewed monthly during Facility Safety meeting and then reviewed at QCI committee which is overseen by the ED.	
K010062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observation and interview, the facility failed to ensure only one type of sprinkler head, i.e., quick response or standard sprinklers was installed in a compartmented space in 4 of 9 smoke compartments. NFPA 13, 1999 Edition, Installation of Sprinkler Systems,	K010062	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? 1. Sprinklers heads have been ordered from Tri State Fire Protection. Sprinkler Heads will be replaced in Physical Therapy room, C and D halls and at	05/29/2014

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	5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a smoke compartment shall be changed. This deficient practice could affect up to 34 residents, staff and visitors in the C and D Halls, plus up to 5 residents, staff and visitors while in the Physical Therapy room. Findings include: Based on observations on 04/29/14 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Maintenance Supervisor, the following compartmented areas had a mixture of quick response sprinkler heads with standard response sprinkler heads installed: a. The Physical Therapy room had two quick response sprinkler heads and seven standard response sprinkler heads b. The C and D Hall entrance lounge had two quick response sprinkler heads and five standard response sprinkler heads c. The C Hall Nurse's Station/TV Lounge/Dining Room area had one quick response sprinkler head and seven standard response sprinkler heads d. The D Hall Nurse's Station/TV Lounge/Dining Room area had one quick response sprinkler head and eight standard response sprinkler heads.		nurses stations for both. 2. Sprinkler heads in Dishwashing room will be replaced. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potental to be affected by the alleged deficient practice. Maintenance Director/Designee will ensure that Sprinkler heads are replaced as per above. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? 1. Sprinklers heads have been ordered from Tri State Fire Protection. Sprinkler Heads will be replaced in Physical Therapy room, C and D halls and at nurses stations for both. 2. Sprinkler heads in Dishwashing room will be replaced. Sprinkler head inspections have been added to the Maintenance Montly PML's How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director/Designee will inspect 5 Sprinkler heads weekly for 4 weeks and then Bi-weekly for two months and then Monthly there after. The monthly Sprinkler inspections will be reviewed monthly during Facility Safety meeting and then reviewed at QCI committee which is overseen	

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	This was acknowledged by the Maintenance Supervisor at the time of each observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of over 500 sprinkler heads in the facility were free of corrosion. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be free of paint and corrosion. Any sprinkler shall be replaced that is painted or corroded. This deficient practice could affect mostly kitchen staff. Findings include: Based on observation on 04/29/14 at 1:35 p.m. during a tour of the facility with the Maintenance Supervisor, the two sprinkler heads in the dishwashing room were covered with corrosion. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		by the ED.	
K010066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and			

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	include no less than the following provisions: (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. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (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			
	Based on observation, record review, and interview; the facility failed to ensure cigarette butts were properly disposed of at 1 of 2 areas where cigarettes were smoked. This deficient practice could affect mostly staff who smoke outside the Dietary short exit corridor, plus any other residents, staff or visitors outside this exit door. Findings include: Based on observation on 04/29/14 at 1:45 p.m. during a tour of the facility with the Maintenance Supervisor, the area outside the Dietary short exit corridor was	K010066	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All Cigarettes were cleaned from Storage area and all staff was notified that there is to be no smoking in that area. Any one caught smoking in that area of the building will be written up and it could lead to termination. Also as of 1 July 2014 the grounds will become smoke free to all Staff. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potental to be affected by the	05/29/2014

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	155148		04/29/2014

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	littered with at least one hundred cigarette butts. At least ten cigarette butts were also observed within the metal cage which contained three helium cylinders and one oxygen cylinder. This was acknowledged by the Maintenance Supervisor at the time of observation. Based on review of the smoking policy at 10:00 a.m. with the Maintenance Supervisor present, the area outside the Dietary short exit corridor was not considered a smoking area. 3.1-19(b)		alleged deficient practice. All Cigarettes were cleaned from Storage area and all staff was notified that there is to be no smoking in that area. Any one caught smoking in that area of the building will be written up and it could lead to termination. Also as of 1 July 2014 the grounds will become smoke free to all Staff. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? All Cigarettes were cleaned from Storage area and all staff was notified that there is to be no smoking in that area. Any one caught smoking in that area of the building will be written up and it could lead to termination. Also as of 1 July 2014 the grounds will become smoke free to all Staff. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director/Designee will inspect storage are x 5 weekly for 4 weeks and then Bi-weekly for two months and then Monthly there after. The monthly inspections will be reviewed monthly during Facility Safety meeting and then reviewed at QCI committee which is overseen by the ED.	
K010069 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in			

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	accordance with 9.2.3. 19.3.2.6, NFPA 96 1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect mostly kitchen staff. Findings include:	K010069	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The contracted company that does our range inspections has been notified to provide us with copies of the last 12 months inspections, and a binder will be put into use to keep current inspections and past and up to date as required for review. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potental to be affected by the alleged deficient practice. The contracted company that does our range inspections has been notified to provide us with copies of the last 12 months inspections, and a binder will be put into use to keep current inspections and past and up to date as required for review. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? The contracted company that does our range inspections has been notified to provide us with copies of the last 12 months inspections, and a binder will be put into use to keep current inspections and past and up to date as required for review. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what	05/29/2014

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	Based on review of the kitchen range inspection reports in the Life Safety Code Documentation book on 04/29/14 at 11:00 a.m. with the Maintenance Supervisor present, there was no documentation to show the kitchen range hood had been inspected semiannually. The most recent kitchen range hood inspection report was dated 03/14 (no day of month provided). There was no prior inspection date available. This was acknowledged by the Maintenance Supervisor at the time of record review. Based on observation at 1:30 p.m. during a tour of the facility with the Maintenance Supervisor, there was only one date (03/14) on the sticker on the kitchen range hood to indicated the range hood had been inspected with no prior date provided. This was confirmed by the Maintenance Supervisor at the time of observation. 3.1-19(b) 2. 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, furthermore, the facility failed to ensure all components of the range hood fire extinguishing system were in proper operating condition. LSC		quality assurance program will be put into place?The Maintenance Director/Designee will ensure monthly that the inspections are current and sign off that the inspection is up to date. During monthly safety meetings it will be confirmed that the range inspecions are current and up to date and then Reviewed during Monthly CQI Committee Meeting which is overseen by the ED.	

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	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 mostly kitchen staff. Findings include: Based on review of the range hood inspection reports in the Life Safety Code Documentation book on 04/29/14 at 11:00 a.m. with the Maintenance Supervisor present, there was no documentation to show the kitchen range hood's fire extinguishing equipment was inspected every six months. The most resent range hood fire extinguishing equipment inspection report was dated 04/23/14. The previous inspection report available was dated 05/01/13, which was			

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	almost twelve months prior to the most recent inspection date. This was acknowledged by the Maintenance Supervisor at the time of record review. 3.1-19(b)			
K010147 SS=E	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 power strips were not used as a substitute for fixed wiring in 2 of 56 resident rooms plus one employee room. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 4 residents in resident rooms 118 and 124, as well as staff while in the Clean Utility room in the F Hall. Findings include: Based on observations on 04/29/14 between 12:00 p.m. and 2:00 p.m. during	K010147	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All equipment was unplugged and removed from powerstrips in rooms 118 and room 124 and also in the Clean utility room on F Hall. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potental to be affected by the alleged deficient practice. All equipment was unplugged and removed from powerstrips in rooms 118 and room 124 and also in the Clean utility room on F Hall. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? Power stripes will be removed from rooms and new outlets will be ran to meet the needs of residents use of equipment. How the	05/29/2014

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	a tour of the facility with the Maintenance Supervisor, resident rooms 118 and 124 had beds plugged into power strips, and the Clean Utility room in the F Hall had a small refrigerator plugged into a power strip. At the time of each observation, the Maintenance Supervisor acknowledged the use of the power strips. 3.1-19(b)		corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance Director/Designee will check 5 rooms weekly for 4 weeks then 5 rooms Bi-monthly for 2 months then monthly there after. Use of power strips will be reviewed in Safety meetings monthly and reviewed in CQT Committee meetings monthly overseen by ED	
K010154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to provide a complete written policy for the protection of 94 of 94 residents containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water-Based	K010154	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Policy has been re-written to enclude procedures to be followed in the event the fire alarm system has be placed out of service for more than 4 hours or more in a 24 hour period. Policy and procedure to enclude how staff is to respond and monitor incare the alarm system is down. How other residents having the potential to be affected by the same deficient practice will	05/29/2014

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	Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of the Fire Watch Policy and Procedure on 04/29/14 at 11:30 a.m. with the Maintenance Supervisor present, the facility's written policy and procedure for an impaired fire protection system stated "out of service for a period of time longer than 4 hours." It did not include "or more in a 24 hour period" at the end of the statement. Furthermore, the policy did include phone numbers for the local fire department and the Indiana State Department of Health. Based on interview at the time of record review, this was acknowledged by the Maintenance Supervisor. 3.1-19(b)		be identified and what corrective actions will be taken? All residents have the potental to be affected by the alleged deficient practice. Policy has been re-written to enclude procedures to be followed in the event the fire alarm system has be placed out of service for more than 4 hours or more in a 24 hour period. Policy and procedure to enclude how staff is to respond and monitor incare the alarm system is down. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? Policy has been re-written to enclude procedures to be followed in the event the fire alarm system has be placed out of service for more than 4 hours or more in a 24 hour period. Policy and procedure to enclude how staff is to respond and monitor incase the alarm system is down. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance Director/Designee will check nursing stations for policy and procedures for monitoring for fire incase alarm system is down weekly for 4 weeks then Bi-monthly for 2 months then monthly there after. Use of power strips will be reviewed in Safety meetings monthly and reviewed in CQT Committee meetings	

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			monthly overseen by ED	
K010155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to provide a complete written policy for the protection of 94 of 94 residents containing procedures to be followed in the event the fire alarm system has to be placed out of services for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm	K010155	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Policy has been re-written to enclude procedures to be followed in the event the fire alarm system has be placed out of service for more than 4 hours or more in a 24 hour period. Policy and procedure to enclude how staff is to respond and monitor incare the alarm system is down. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potental to be affected by the alleged deficient practice. Policy has been re-written to enclude procedures to be followed in the event the fire alarm system has be placed out of service for more than 4 hours or more in a 24 hour period. Policy and procedure to enclude how staff is to respond and monitor incare the alarm system is down. What measures will be put into place or	05/29/2014

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	system. This deficient practice could affect all occupants in the facility including residents, staff, and visitors. Findings include: Based on review of the Fire Watch Policy and Procedure on 04/29/14 at 11:30 a.m. with the Maintenance Supervisor present, the facility's written policy and procedure for an impaired fire protection system stated "out of service for a period of time longer than 4 hours." It did not include "or more in a 24 hour period" at the end of the statement. Furthermore, the policy did include phone numbers for the local fire department and the Indiana State Department of Health. Based on interview at the time of record review, this was acknowledged by the Maintenance Supervisor. 3.1-19(b)		what systemic changes will be made to ensure that deficient practice does not recur? Policy has been re-written to enclude procedures to be followed in the event the fire alarm system has be placed out of service for more than 4 hours or more in a 24 hour period. Policy and procedure to enclude how staff is to respond and monitor incase the alarm system is down. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance Director/Designee will check nursing stations for policy and procedures for monitoring for fire incase alarm system is down weekly for 4 weeks then Bi-monthly for 2 months then monthly there after. Use of power strips will be reviewed in Safety meetings monthly and reviewed in CQT Committee meetings monthly overseen by ED	