

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155752	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2015
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NAME OF PROVIDER OR SUPPLIER MORNINGSIDE NURSING AND MEMORY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 18325 BAILEY AVE SOUTH BEND, IN 46637
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K 000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/05/15</p> <p>Facility Number: 004732 Provider Number: 155752 AIM Number: 200808300</p> <p>Surveyors: Amy Kelley, Life Safety Code Specialist and Scott Wytosick, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Morningside Nursing and Memory Care 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 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with automatic smoke</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025 SS=D Bldg. 01	<p>detection in the corridors, in areas open to the corridors, and battery operated smoke alarms in resident rooms 110, 111, and 114 and hard wired smoke detectors in resident room 100, 112, 113, 115 and 116. The remaining 8 resident rooms lack smoke detection. The facility has a capacity of 40 and had a census of 32 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered with the exception of a wood shed.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/16/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-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 in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke</p>			

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	<p>barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 1 of 1 smoke barrier walls were maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Maintenance Technician #1 on 03/05/15 from 1:47 p.m. to 2:00 p.m., the following smoke barrier wall penetration and unsealed ceiling penetrations were noted:</p> <p>a) There was a three foot by six foot hole in the attic smoke barrier wall.</p> <p>b) In the sprinkler riser closet measuring two inches around the main sprinkler line</p> <p>c) In the IT closet there were two penetrations measuring five eights inch around wiring and a conduit</p> <p>d) In the mechanical room there were three penetrations measuring from three fourths inch to one and one fourths inch around conduit</p> <p>e) In the staff entrance corridor measuring one inch around conduit</p>	K 025	<p>No residents were affected by this citation.</p> <ol style="list-style-type: none"> The attic smoke barrier wall was sealed The hole in the sprinkler riser closet around the main sprinkler line was sealed. The two penetrations in the IT closet were sealed The hole around the conduit in the staff entrance corridor was sealed <p>The maintenance supervisor or designee will monitor these areas during their monthly rounds and document their findings on their rounds forms. The administrator will review the rounds sheets monthly. The quality assurance committee will review the sheets monthly for three months. If compliance is achieved, then monitoring by the quality assurance committee will be discontinued. The correct documentation showing the correct product used is attached.</p> <p>1.</p>	03/20/2015			

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K 029 SS=D Bldg. 01	<p>Based on interview at the time of each observation, the Maintenance Director acknowledged and provided the measurements for each unsealed penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 water heater rooms, a hazardous area, was provided with a self closing device. This deficient practice was not in a resident care area but could affect staff.</p> <p>Findings include:</p> <p>Based on observation and interview on 03/05/15 at 2:24 p.m., the Maintenance Director acknowledged the corridor door entering the water heater room from the break room corridor lacked a self closing device.</p> <p>3.1-19(b)</p>	K 029	<p>No residents or staff were affected by this citation. A self-closing device has been installed on the corridor door entering the water heater room</p> <p>A form to document monitoring of the door has been developed and placed on the door. The form indicates the date tested, whether or not it passed or failed the test, and a place for the name of the person who tested the door. The maintenance supervisor or designee is responsible to check the door on a monthly basis to ensure proper closure. Monitoring will be ongoing.</p>	03/11/2015

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K 047 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed with continuous illumination also served by the emergency lighting system in accordance with section 7.10. 18.2.10.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 exit signs above the southeast hall exit door lead in the direction of the exit. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. This deficient practice could affect could affect 18 resident on the southeast hall.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director and Maintenance Technician #1 on 03/05/15 at 1:25 p.m., the direction arrow on the exit sign above the southeast hall exit door pointed right. Based on an interview with the Maintenance Director at the time of observation, residents were to proceed left and continue down the sidewalk to the public way.</p> <p>3.1-19(b)</p>	K 047	No residents were affected by this citation. The directional arrow on the exit sign was changed to point left. Monitoring is not necessary, as the correction has been made and the arrow will permanently remain pointing in the correct direction.	03/06/2015

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K 048 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1</p> <p>Based on record review and interview, the facility failed to provide a written plan that included the evacuation of smoke compartments in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (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 <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a record review and interview on 03/05/15 at 1:00 p.m., Maintenance Technician #1 acknowledged the "General Evacuation Plan Procedure" did not address evacuation of smoke compartment.</p>	K 048	No residents were affected by this citation. The "General Evacuation Plan Procedure" has been updated to address the evacuation of the smoke compartment. The "General Evacuation Plan" will be reviewed at the next Quality Assurance Committee meeting to ensure compliance. The committee will review the plan twice per year to ensure continuing compliance. The Administrator or designee is responsible to update the plan when changes are necessary.	03/20/2015			

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K 050 SS=F Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 3 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Fire Drill Report" with the Maintenance Director and Maintenance Technician #1 on 03/05/15 at 11:15 a.m., there was no record of a third shift fire drill for the second and fourth quarters of 2014 and a second shift fire drill for the third quarter of 2014. Based on an interview with Maintenance Technician #1 at the time of record review, he was confused and</p>	K 050	<p>No residents were affected by this citation. Fire drills are held on each shift on a quarterly basis. A form labeled "Fire Drill Log" has been developed which indicates the month and the shift in which fire drills will be held. The Maintenance Director and Maintenance Technician #1 were in-serviced regarding the requirement as well as proper completion of the form. The administrator will review the fire drills monthly to ensure they are completed timely. The quality assurance committee will review the fire drills quarterly, for two quarters to ensure fire drills are completed timely. If compliance is determined, then the monitoring will be discontinued.</p>	03/31/2015

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K 052 SS=F Bldg. 01	<p>attempted to make up missed fire drills in the next quarter.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>1) Based on record review and interview, the facility failed to ensure 32 of 32 smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent</p>	K 052	<p>No residents were affected by this citation. Even though testing was performed by Koorsen, the documentation was not filed appropriately. The administrator met with Koorsen representative to discuss record-keeping policies and procedures. Koorsen did perform required testing for smoke detectors. Documentation is now available. The administrator and or designee is responsible for monitoring record-keeping and reports on a quarterly basis. The quality assurance committee will review quarterly reports for two quarters to monitor for compliance. If the quality assurance committee deems compliance, then monitoring will be discontinued.</p>	04/04/2015

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	<p>trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director and Maintenance Technician # on 03/05/15 at 12:26 p.m., the most recent documentation of a</p>			

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	<p>smoke detector sensitivity test was completed by Koorsen dated 02/05/13. Based on an interview with Maintenance Director and Maintenance Technician #1 at the time of record review, no other documentation was available for review.</p> <p>3.1-19(b)</p> <p>2) Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect laundry staff.</p> <p>Findings include:</p> <p>Based on record review and interview on 03/05/15 at 11:58 a.m., after review of the quarterly fire alarm inspection reports from Ryan Fire Protection Inc., the Maintenance Technician #1 acknowledged the smoke detector in the laundry did not receive an annual test for</p>			

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K 056 SS=E Bldg. 01	<p>the previous year.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. 1. Based on observation and interview, the facility failed to ensure only one type of sprinkler head i.e. quick response or standard sprinklers were installed in 2 of 2 corridors and 1 of 2 shower rooms. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 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 all occupants.</p>	K 056	No residents were affected by this citation. The facility is currently gathering bids for replacement of the sprinkler heads, and relocation of the two sprinkler heads in the closets. Once the bids have been reviewed, we will choose a contractor to make the necessary changes. Upon completion of the changes to the system, an inspection to determine compliance will be conducted. After the initial inspection, quarterly inspections to ensure continued compliance will be conducted. The maintenance	06/01/2015

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	<p>Findings include:</p> <p>Based on observations on 03/05/15 from 1:32 p.m. to 2:22 p.m., the Maintenance Director and Maintenance Technician #1 acknowledged the southeast and the northeast hall and the southeast shower room had a mixture of quick response sprinkler heads and standard response sprinkler heads.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 2 sunroom closets had sprinkler heads installed at least four inches from the wall. NFPA 13, 5-6.3.3 requires upright and pendant sprinkler heads shall be installed at least four inches from the wall. This deficient practice was not in a resident care area but could affect staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 03/05/15 at 1:18 p.m., the sprinkler heads in the sunroom furnace closet and the therapy supply closet had sprinkler heads mounted less than four inches from the wall. Based on an interview at the time of observation, the Maintenance Director confirmed each sprinkler head was</p>		<p>supervisor or designee is responsible to monitor to ensure compliance. The Quality Assurance Committee will review the inspection reports for three quarters to determine compliance. If compliance is determined then monitoring by the Quality Assurance Committee will cease.</p>	

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K 061 SS=F Bldg. 01	<p>mounted one inch from the wall.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 water supply valves was electronically supervised. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation on 03/05/15 at 1:44 p.m., the Maintenance Director confirmed the sprinkler system water supply valve was tied in the open position with a plastic tie strap. Based on an interview at the time of observation, the Maintenance Director acknowledged the water supply lacked an electronic tamper device.</p> <p>3.1-19(b)</p>	K 061	<p>No residents have been affected by this citation. The facility is obtaining bids for installation of an electronic tamper device. Once bids have been received and reviewed, we will choose a contractor to install the tamper device. Upon completion of installation, the system will be inspected to ensure proper functioning. The tamper device will be monitored on a quarterly basis along with the required monitoring of the fire protection system. The maintenance supervisor or designee is responsible to ensure that the inspections are completed as scheduled. The Quality Assurance Committee will review the inspections for two quarterly meetings to ensure compliance. If compliance is determined, then monitoring by the Quality Assurance Committee will stop.</p>	06/01/2015

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K 062 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition 2-4.1.4 which requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 03/05/15 at 2:19 p.m., there was a side wall mounted sprinkler head in the miscellaneous storage room of the break room corridor. Based on observation at 1:56 p.m., the Maintenance Director confirmed the</p>	K 062	No residents were affected by this citation. Side wall sprinkler heads were ordered, and will be placed in the cabinet that holds spare sprinkler heads. The maintenance director or designee will monitor the cabinet on a monthly basis to ensure that the correct spare sprinkler heads are included. The administrator will review on a monthly basis, with the maintenance director to ensure there are adequate spare sprinkler heads. The administrator will review this information quarterly with the quality assurance committee for one quarter. If the quality assurance committee deems this corrected, then monitoring will be discontinued.	04/03/2015			

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K 067 SS=F Bldg. 01	<p>spare sprinkler cabinet lacked side wall sprinkler heads.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A</p> <p>Based on record review and interview, the facility failed to ensure 3 of 3 fire/smoke dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p>	K 067	<p>No residents were affected by this citation. Arrangements have been made with the facility's contractor to inspect the dampers. Dates regarding the next four-year inspection will be entered into the maintenance logs to ensure that the required inspection is carried out. The maintenance supervisor or designee is responsible to monitor to assure compliance. The quality assurance committee will review the maintenance logs at the quarterly quality assurance meeting. If the committee determines that compliance is achieved, then no further monitoring will be required.</p>	04/04/2015

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K 130 SS=E Bldg. 01	<p>Based on record review with the Maintenance Director and the Maintenance Technician #1 on 03/05/15 at 12:20 p.m., the last inspection for the three dampers in the facility was 09/02/10 completed by H&G. Based on an interview at the time of record review, Maintenance Technician #1 acknowledged the three dampers had not been inspected since 2010.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview, the facility failed to ensure a battery testing and replacement program was provided to ensure 3 of 3 single station smoke alarms would operate. This deficient practice affects 4 residents.</p> <p>Findings include:</p> <p>Based on record review and interview on 03/05/15 at 12:25 p.m., the Maintenance Director acknowledged the facility lacked a battery testing and replacement program for the three single station smoke alarms installed in resident rooms</p>	K 130	No residents were affected by this citation. The policy for battery powered smoke detectors was updated to include battery replacement and testing. This was reviewed with the maintenance supervisor and technician. Battery testing and replacement will be done according to the policy and procedure, and documented in the maintenance logs. Monitoring of following the policy will be conducted by the administrator monthly to ensure compliance with the policy. The quality assurance committee will review the maintenance logs monthly for three months to ensure	03/19/2015

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K 147 SS=D Bldg. 01	<p>110, 111, and 114.</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 1 of 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring. 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 was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation and interview, the Maintenance Director acknowledged a light weight extension cord was plugged in and providing power to a freezer located in the kitchen.</p> <p>3.1-19(b)</p>	K 147	<p>compliance. If compliance is reached, then monitoring by the quality assurance committee will cease.</p> <p>No residents were affected by this citation. The extension cord was removed. An outlet with fixed wiring was installed. The Administrator or designee is responsible to monitor for the use of extension cords. The "Rounds Sheet" used by department managers during their rounds includes an area for documenting observations of the use of extension cords. The Quality Assurance Committee will review the rounds sheets once per month for three months to determine compliance in this area. If compliance is determined, then monitoring by the Quality Assurance Committee will cease.</p>	03/24/2015			

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K 154 SS=C Bldg. 01	<p>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</p> <p>Based on record review and interview, the facility failed to provide a written policy 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. in order to protect 32 of 32 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, A-11-5(c) 2 states, "a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly." This</p>	K 154	No residents were affected by this citation. The fire watch policy was updated to include the statement that the person conducting the fire watch - no other duties will be assigned to the responsible individual while conducting the fire watch. No further monitoring is required, as the policy has been updated.	03/09/2015

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K 155 SS=C Bldg. 01	<p>deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview with the Maintenance Director and Maintenance Technician #1 on 03/05/15 at 11:19 a.m., the facility did have a written fire watch policy and procedure for a sprinkler system failure but it did not address all components of NFPA 25, Chapter 11. Specifically, the plan did not state the person conducting the fire watch shall be assigned no other duties during that time.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on record review and interview, the facility failed to ensure its written fire watch policy addressed all procedures to be followed in this facility in the event the fire alarm system has to be placed out</p>	K 155	No residents were affected by this citation. The fire watch policy was updated to include the statement that the person conducting the fire watch that no other duties will be assigned to the responsible individual. No further monitoring	03/09/2015

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K 999 Bldg. 01	<p>of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 in order to protect 32 of 32 residents. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview with the Maintenance Director and Maintenance Technician #1 on 03/05/15 at 11:19 a.m., the facility did have a written fire watch policy and procedure for a fire alarm system failure but it did not address all components of LSC Section 9.6.1.8. Specifically, the plan did not state the person conducting the fire watch shall be assigned no other duties during that time.</p> <p>3.1-19(b)</p> <p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p>	K 999	<p>is required, as the policy has been updated.</p> <p>This facility respectfully requests an Informal Deficiency Resolution related to this citation. No residents were affected by this citation. On July 17, 2002, a</p>	03/05/2015			

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	<p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to install smoke detectors in each resident's room before July 1, 2012. This deficient practice could affect 16 residents in the facility.</p> <p>Findings include:</p> <p>Based on interview with the Maintenance Director and Maintenance Technician #1 on 03/05/14 at 11:58 p.m., resident rooms 101 through 108 were not provided with a smoke detector or a smoke alarm. Based on observation with the</p>		<p>"Quality Assurance Walk-thru Survey" was conducted by Life Safety Code Specialist. During the survey, the specialist found the facility to be in compliance with state law in regard to sprinkler coverage and smoke detector coverage. A Quality Review by the Life safety Code Supervisor was conducted on 7/23/2012.</p>	

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	Maintenance Director and Maintenance Technician #1 during a tour of the facility from 1:20 p.m. and the Maintenance Supervisor acknowledged not all the resident rooms were provided with smoke detectors. 3.1-19(ff)						