

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/04/2015
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NAME OF PROVIDER OR SUPPLIER  ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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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: 02/04/15</p> <p>Facility Number: 000135 Provider Number: 155230 AIM Number: 100266820</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Rosebud Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of type V (000) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility</p>	K010000	<p>This Plan of Correction constitutes the centers Allegation of Compliance. The following Plan of Correction is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and the Plan of Correction does not constitute an admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</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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K010025 SS=E	<p>has a capacity of 110 and had a census of 105 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has one detached wooden storage building used for storage which was not sprinkled.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 02/11/15.</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 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</p> <p>Based on observations and interview, the facility failed to ensure the smoke barriers in 1 of 1 ceiling and 2 of 10 attic</p>	K010025	<p>K025</p> <p><b>What corrective action will takeplace for those residents found to be affected by the deficient</b></p>	02/23/2015

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	<p>smoke barriers were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 26 residents who reside on the Station 2 Hall.</p> <p>Findings include:</p> <p>Based on observations with the administrator during a tour of the facility on 02/04/15 from 9:00 a.m. to 12:45 p.m., the following locations had ceiling and attic smoke barrier penetrations not firestopped or missing drywall;</p> <ol style="list-style-type: none"> <li>1. The Service Hall sprinkler riser room ceiling had a four inch open electrical conduit not fire stopped, a two inch gap around a water pipe penetration, and a one half inch gap around a computer cable penetration not fire stopped.</li> <li>2. The kitchen mop closet ceiling had a three inch circular area of drywall missing.</li> <li>3. The Station 2 Hall attic smoke barrier wall had a two inch gap around a circular</li> </ol>		<p><b>practice?</b></p> <p>No residents were affected; however for those 26 having the potential to be affected all areas have been corrected. The service hall sprinkler riser room ceiling has been fire stopped in the three areas identified. The kitchen mop closet ceiling has been fire stopped. The station two attic smoke barrier wall has been fire stopped around both areas identified. The station three attic smoke barrier wall penetrations filled with orange expandable foam has been replaced with firestopping material.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b></p> <p>All residents had the potential to be affected. Maintenance Director ensured that all areas have been corrected and all other areas inspected to ensure no other deficiencies. The service hall sprinkler riser room ceiling has been fire stopped in the three areas identified. The kitchen mop closet ceiling has been fire stopped. The station two attic</p>				

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K010027 SS=E	<p>water pipe penetration not fire stopped, a two inch gap around a two foot by two foot duct penetration not fire stopped on both sides of the attic smoke barrier wall.</p> <p>4. The Station 3 Hall attic smoke barrier wall had six penetrations filled with orange expandable foam fire stopping material. Based on an interview with the administrator at the time of observation, there was no documentation available for review the expandable foam material was an acceptable fire stopping material. The Service Hall sprinkler riser room ceiling, kitchen mop closet ceiling not fire stopped, and Station 2 Hall and Station 3 Hall attic smoke barrier penetrations not fire stopped was verified by the administrator at the time of observations and acknowledged by the administrator at the exit conference on 02/04/15 at 12:45 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not</p>		<p>smokebarrier walls have been fire stopped around both areas identified. The station three attic smoke barrier wallpenetrations filled with orange expandable foam has been replaced with firestopping material.</p> <p><b>What measures will be put into placeor what systemic changes will be made to ensure that the deficient practicedoes not reoccur?</b> Executive Director providedin-service to Maintenance Director on the NFPA 101 Life Safety Code Standard. Maintenance will monitor all contractedcompanies to ensure that no deficient area is left after work completed.</p> <p><b>How will the correctiveactions be monitored to ensure they do not occur again?</b> A CQI monitoringtool will be completed by Maintenance Director weekly times four weeks and thenmonthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQIcommittee and action plans will be developed as needed if the threshold of 95%is not met.</p>		

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	<p>exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 3 of 10 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 21 residents who reside on the A Hall and 36 residents who reside on the Station 2 and Station 3 Halls.</p> <p>Findings include:</p> <p>Based on observations on 02/04/15 from 9:45 a.m. to 12:45 p.m. with the administrator, the Service Hall set of smoke barrier doors by the maintenance office, the set of smoke barrier doors between the Station 2 Hall and Station 3 Hall, and the A Hall set of smoke barrier doors had between a one inch gap and a two inch gap along the center where the</p>	K010027	<p>K027</p> <p><b>What corrective action will takeplace for those residents found to be affected by the deficient practice?</b></p> <p>No residents wereaffected; however for those 57 having the potential to be affected all areashave been corrected. The service hallset of smoke barrier doors by the maintenance office, the set of smoke barrierdoors between the station 2 hall and station 3 hall and the A hall set of smokebarrier doors have been corrected to close the opening leaving only the minimumclearance necessary for proper operation 1/8 inch or less.</p> <p><b>How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?</b></p> <p>Allresidents had the potential to be affected. Maintenance Director ensured that all areas have been</p>	02/23/2015

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K010029	doors came together in the closed position. This was verified by the administrator at the time of observations and acknowledged by the administrator at the exit conference on 02/04/15 at 12:45 p.m.  3.1-19(b)  NFPA 101		corrected and allother areas inspected to ensure no other deficiencies. The service hall set of smoke barrier doorsby the maintenance office, the set of smoke barrier doors between the station 2hall and station 3 hall and the A hall set of smoke barrier doors have beencorrected to close the opening leaving only the minimum clearance necessary forproper operation 1/8 inch or less.  <b>What measures will be put into placeor what systemic changes will be made to ensure that the deficient practicedoes not reoccur?</b> Executive Director providedin-service to Maintenance Director on the NFPA 101 Life Safety Code Standard. Maintenance Director will check all doorsmonthly to ensure compliance.  <b>How will the correctiveactions be monitored to ensure they do not occur again?</b> A CQI monitoringtool will be completed by Maintenance Director weekly times four weeks and thenmonthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQIcommittee and action plans will be developed as needed if the threshold of 95%is not met.		

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SS=A	<p><b>LIFE SAFETY CODE STANDARD</b> One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observations and interview, the facility failed to ensure 1 of 14 hazardous areas, such as a laundry room over 100 square feet, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice affects staff only who work in the Service Hall laundry room.</p> <p>Findings include:</p> <p>Based on observation on 02/04/15 at 10:20 a.m. with the administrator, the laundry room, which measured two hundred twenty square feet, and stored twelve shelves of combustible clean linen, had a two inch gap when the door was allowed to self close and failed to latch into the door frame. This was verified by the administrator at the time of observation and acknowledged by the administrator at the exit conference on</p>	K010029	<p>K029 - A Form</p> <p><b>What corrective action will takeplace for those residents found to be affected by the deficient practice?</b></p> <p>No residents had thepotential to be affected and the Maintenance Director ensured that thehazardous area door provided with a self closing device now latches into thedoor frame per NFPA requirements and will be inspected monthly.</p> <p><b>How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?</b></p> <p>No residents had thepotential to be affected and the Maintenance Director ensured that thehazardous</p>	02/23/2015	



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	<p>continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to ensure 1 of 27 exit signs was continuously illuminated. This deficient practice could affect 76 residents who use the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 02/04/15 at 10:50 a.m., the exit sign located at the main dining room entrance was not illuminated. Based on interview at the time of observation, the administrator indicated the light bulb was burned out. This was acknowledged by the administrator at the exit conference on 02/04/15 at 12:45 p.m.</p> <p>3.1-19(b)</p>	K010047	<p>K047</p> <p><b>What corrective action will takeplace for those residents found to be affected by the deficient practice?</b></p> <p>No residents wereaffected; however for those 76 having the potential to be affected the area hasbeen corrected. The exit sign iscontinuously illuminated as the bulb was replaced.</p> <p><b>How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?</b></p> <p>Allresidents had the potential to be affected. Maintenance Director ensured that the exit sign is continuouslyilluminated and all other areas inspected to ensure no other deficiencies.</p> <p><b>What measures will be put into placeor what systemic changes will be made to ensure that the deficient practicedoes not reoccur?</b></p> <p>Executive Director providedin-service to Maintenance Director on the NFPA 101 Life Safety Code Standard. Maintenance Director will inspect all exitsigns weekly to ensure continuously illuminated.</p>	02/23/2015	

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K010056 SS=E	<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 7 of 12 resident room shower rooms on the Medicare Hall were sprinkled. This deficient practice affects 7 residents who reside on the Medicare Hall.</p> <p>Findings include:</p>	K010056	<p><b>How will the corrective actions be monitored to ensure they do not occur again?</b> A CQI monitoring tool will be completed by Maintenance Director weekly times four weeks and then monthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 95% is not met.</p> <p>K056 <b>What corrective action will take place for those residents found to be affected by the deficient practice?</b> No residents were affected; however for those 7 having the potential to be affected the area has been corrected.</p>	02/23/2015

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	<p>Based on observations on 02/04/15 during a tour of the Medicare Hall from 11:55 a.m. to 12:35 p.m. with the administrator, resident rooms 1, 3, 5, 7, 10, 12, and 14 each had no sprinkler coverage in the shower portion of the bathrooms. This was verified by the administrator at the time of observations and acknowledged by the administrator at the exit conference on 02/04/15 at 12:45 p.m.</p> <p>3.1-19(b)</p>		<p>Resident rooms 1, 3, 5, 7, 10, 12 and 14 have adequate sprinkler coverage in the resident room showerroom.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> All residents had the potential to be affected. Maintenance Director ensured that the 7 resident room shower rooms are adequately sprinkler covered and all other areas inspected to ensure no other deficiencies.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> Executive Director provided in-service to Maintenance Director on the NFPA 101 Life Safety Code Standard.</p> <p><b>How will the corrective actions be monitored to ensure they do not occur again?</b> A CQI monitoring tool will be completed by Maintenance Director weekly times four weeks and then monthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQI committee and action plans will be developed as</p>		

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K010062 SS=F	<p>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</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler system components was inspected quarterly for 1 of 4 calendar quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents in the facility.</p> <p>Findings include:  Based on sprinkler system record review with the administrator on 02/04/15 at 9:00 a.m., there was no third quarter</p>	K010062	<p>K062 needed if the threshold of 95% is not met.</p> <p><b>What corrective action will take place for those residents found to be affected by the deficient practice?</b> All residents had the potential to be affected and the Maintenance Director ensured that the sprinkler system was inspected in the fourth quarter 2014 and tested per NFPA requirements first quarter 2015 to ensure the system is in full compliance. The administrator office sprinkler, two sprinklers in the main dining room, the sprinkler in room 41 and two laundryroom sprinklers were provided escutcheons and are flush with the ceiling to ensure no gap to the attic space above.</p> <p><b>How other residents having</b></p>	02/23/2015			

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	<p>(July, August, September) of 2014 sprinkler system inspection report available for review. Based on interview with the administrator on 02/04/15 during record review, the administrator indicated there was no written documentation or other evidence the sprinkler system had been inspected during the third quarter of 2014 and verified no records were available with the sprinkler inspection company during a telephone call on 02/04/15 at 9:20 a.m. The lack of a quarterly sprinkler system inspection conducted for the third quarter of 2014 was verified by the administrator at the time of record review and acknowledged at the exit conference on 02/04/15 at 12:45 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 4 of over 300 sprinkler heads in the facility were maintained. This deficient practice could affect 76 residents who use the main dining room and 2 residents who reside in resident room 41.</p> <p>Findings include:</p> <p>Based on observations on 02/04/15 during a tour of the facility from 9:00 a.m. to 12:45 p.m. with the administrator,</p>		<p><b>thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?</b></p> <p>All residents had thepotential to be affected and the Maintenance Director ensured that thesprinkler system was inspected in the fourth quarter 2014 and tested per NFPArequirements first quarter 2015 to ensure the system is in fullcompliance. The administrator office sprinkler,two sprinklers in the main dining room, the sprinkler in room 41 and twolaundry room sprinklers were provided escutcheons and are flush with theceiling to ensure no gap to the attic space above and all other areas inspectedto ensure no other deficiencies .</p> <p><b>What measures will be put into placeor what systemic changes will be made to ensure that the deficient practicedoes not reoccur?</b></p> <p>Executive Director providedin-service to Maintenance Director on the NFPA 101 Life Safety Code Standard. Maintenance Director</p>		

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NAME OF PROVIDER OR SUPPLIER  ROSEBUD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374			
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K010064 SS=C	<p>the administrator office sprinkler, two sprinklers in the main dining room, the sprinkler in resident room 41, and two laundry room sprinklers lacked escutcheons and were not flush to the ceiling leaving between a one half inch and one inch gap into the attic space above. This was verified by the administrator at the time of observations and acknowledged at the exit conference on 02/04/15 at 12:45 p.m.</p> <p>3.1-19(b)</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 ensure 12 of 12 portable fire extinguishers were inspected at least monthly and the inspections were documented for 2 of 2 months since the annual inspection, including the date and initials of the person performing the inspection. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be</p>	K010064	<p>will review random sample of sprinkler heads to ensure escutcheons in place monthly. Maintenance Director will monitor inspection company to ensure all inspections completed timely.</p> <p><b>How will the corrective actions be monitored to ensure they do not occur again?</b> A CQI monitoring tool will be completed by Maintenance Director weekly times four weeks and then monthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 95% is not met.</p> <p>K064 <b>What corrective action will take place for those residents found to be affected by the deficient practice?</b> All residents had the potential to be affected and the Maintenance Director ensured that the portable fire extinguishers were inspected 2/9/15 per NFPA requirements and will be inspected monthly.</p>	02/23/2015			

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	<p>recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. This deficient practice could affect all clients, visitors and staff.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the administrator on 02/04/15 from 9:00 a.m. to 12:45 p.m., the service and inspection tags for the twelve portable fire extinguishers located throughout the facility each bore a service inspection tag indicating the most recent annual inspection was conducted on 08/26/14. Furthermore, no inspections were documented on the inspection tags for September, October, November, December 2014 and January 2015.</p> <p>Based on an interview with the administrator on 02/04/15 at 12:30 p.m., there was no other evidence to indicate monthly inspections were conducted on the twelve portable fire extinguishers since the annual inspection date of 08/26/14. This was verified by the administrator at the time of observations and acknowledged at the exit conference on 02/04/15 at 12:45 p.m.</p>		<p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b></p> <p>All residents had the potential to be affected and the Maintenance Director ensured that the portable fire extinguishers were inspected per NFPA requirements and will be inspected monthly.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b></p> <p>Executive Director provided in-service to Maintenance Director on the NFPA 101 Life Safety Code Standard. Maintenance Director will inspect monthly and provide documentation to Executive Director to ensure it is completed timely.</p> <p><b>How will the corrective actions be monitored to ensure they do not occur again?</b></p> <p>A CQI monitoring tool will be completed by Maintenance Director weekly times four weeks and then monthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQI committee and action plans will be developed as</p>	

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K010130 SS=C	<p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview, the facility failed to ensure 3 of 3 boilers had an inspection certificate that was current to ensure the boilers was in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the three A O Smith model hot water heaters inspection certificates with the administrator on 02/04/15 at 9:15 a.m., the inspection certificates had an expiration date of 05/02/14. Based on an interview with the administrator on 02/04/15 at 9:20 a.m., it was stated there are no current two year inspection certificates for the three A O Smith model hot water heaters. The lack of current inspection certificates for the three hot water heaters was acknowledged by the administrator at the exit conference on 02/04/15 at 12:45 p.m.</p>	K010130	<p>K130</p> <p><b>What corrective action will takeplace for those residents found to be affected by the deficient practice?</b></p> <p>All residents had thepotential to be affected and the Executive Director ensured that the threeboilers had a current inspection completed 4/15/14 and the certificate has nowbeen received ensuring the boilers are in safe operating condition per NFPArequirements and will be inspected monthly.</p> <p><b>How other residents having the potentialto be affected by the same deficient practice will be identified and whatcorrective action will be taken?</b></p> <p>All residents had thepotential to be affected and the Executive Director ensured that the threeboilers had a current inspection completed 4/15/14 and the certificate has nowbeen received</p>	02/23/2015			

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	3.1-19(b)		<p>ensuring the boilers are in safe operating condition per NFPA requirements and will be inspected monthly.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> Executive Director provided in-service to Maintenance Director on the NFPA 101 Life Safety Code Standard.</p> <p><b>How will the corrective actions be monitored to ensure they do not occur again?</b> A CQI monitoring tool will be completed by Maintenance Director weekly times four weeks and then monthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 95% is not met.</p>		