

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155238	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2013
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NAME OF PROVIDER OR SUPPLIER WATERS OF YORKTOWN THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 S ANDREWS RD YORKTOWN, IN 47396
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K0000	<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: 01/15/13</p> <p>Facility Number: 000143 Provider Number: 155238 AIM Number: 100283890</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Waters of Yorktown 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 II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in resident sleeping rooms. The facility has</p>	K0000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or</p> <p>Agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p>	

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

TITLE

(X6) DATE

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

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	<p>a capacity of 100 and had a census of 89 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except for the four detached sheds for facility storage which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/22/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0022 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 1 of 1 doors likely to be mistaken for a way of exit was identified as "No Exit." LSC 7.10.8.1 requires any door which is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall be identified by a sign that reads: NO EXIT. This deficient practice could affect 30 residents on 300 hall as well as visitors and staff using the assisted dining room.</p> <p>Findings include:</p> <p>Based on observation on 01/15/13 at 12:20 p.m. with the Maintenance Supervisor, the door leading to the outside of the assisted dining room on 300 hall which appears to be an exit, but is not an exit, does not have a sign indicating whether the door is an exit or is not an exit. Based on interview on 01/15/13 at 12:22 p.m. with the Maintenance Supervisor, it was acknowledged the door leading out of the assisted dining room is not meant to be an exit, however, it could be mistaken for an exit and should have a NO EXIT sign to</p>	K0022	<p>I. A sign that reads "NO EXIT" was immediately hung on the door leading to the outside of the assisted dining room on 300-hallway on January 15, 2013.</p> <p>II. All residents, visitors and staff have the potential to be effected by this practice.</p> <p>III. The Director of Maintenance or his designee observed all facility exits for the same deficiency and no other deficiencies were noted. The appropriate signage on exit doors was included in the preventative maintenance monthly rounds.</p> <p>IV.</p>	02/14/2013
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	try to avoid any confusion. 3.1-19(b)		The Director of Maintenance or his Designee will audit monthly rounds and report findings in the quarterly Quality Assurance meeting. V. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: February 14, 2013		

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 doors leading to hazardous areas on 100 hall such as rooms with combustible items was provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 24 residents on 100 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/15/13 at 12:55 p.m. with the Maintenance Supervisor, the Storage room next to the MDS office on 100 hall containing seventy cardboard boxes inside the room which was greater than fifty square feet in size, did not have a self closing device on the corridor door. Based on interview on 01/15/13 at 12:58 p.m. with the</p>	K0029	<p>I. A self-closing device was placed on the storage room door next to the MDS office on January 16, 2013.</p> <p>II. All residents, visitors and staff have the potential to be effected by this practice.</p> <p>III. The Director of Maintenance or his designee observed all other doors leading to hazardous areas including rooms with combustible items for the same deficiency and no other</p>	02/14/2013			

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	Maintenance Supervisor, it was acknowledged the aforementioned door leading into the Storage room containing combustible items was not equipped with a self closing device on the door. 3.1-19(b)		<p>deficiencies were noted. The appropriate closures for doors leading to hazardous areas were included in the preventative maintenance monthly rounds.</p> <p>IV.</p> <p>The Director of Maintenance or his Designee will audit monthly rounds and report findings in the quarterly Quality Assurance meeting.</p> <p>V.</p> <p>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: February 14, 2013</p>		

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K0038 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observations and interview, the facility failed to ensure exit access was arranged so 1 of 1 exit access doors on Service hall was not equipped with 2 locking devices on the door. Section 19.2.2.2.5 requires means of egress are permitted to be locked, but only one locking device shall be permitted on each door. This deficient practice could affect 1 to 2 staff members as well as other visitors and staff in the facility.</p> <p>Findings include:</p> <p>Based on observation on 01/15/13 at 1:33 p.m. with the Maintenance Supervisor, the Housekeeping closet corridor door had a door knob lock and a deadbolt lock on the door leading out the room. Based on interview on 01/15/13 at 1:34 p.m., it was acknowledged by the Maintenance Supervisor there were two locking devices on the Housekeeping closet corridor door.</p> <p>3.1-19(b)</p>	K0038	<p>I. The deadbolt lock on the Housekeeping closet corridor door in the Service hall was removed on January 16, 2013.</p> <p>II. All visitors and staff have the potential to be effected by this practice.</p> <p>III. No other doors on the Service hall were equipped with two locks. The doors of the Service hall were added to the preventative maintenance monthly rounds.</p> <p>IV. The Director of Maintenance or his designee will audit monthly rounds and report findings in the quarterly Quality Assurance meeting.</p>	02/14/2013

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K0046 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency generator room battery backup lights was tested monthly for 30 seconds or annually for 90 minutes duration to ensure the light would provide lighting during periods of power outages to protect 89 of 89 residents. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. 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. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on observation on 01/15/13 at 2:00 p.m. with the Maintenance Supervisor, the emergency generator location was</p>	K0046	<p>I. The Director of Maintenance or his designee last tested the emergency generator room battery backup lights during the week of December 30, 2012 for 90 minutes and again on January 31, 2013 for 90 minutes. The last monthly test was completed during the week of November 30, 2012 for 30 seconds and will be completed again on February 1, 2013.</p> <p>II. All residents, visitors and staff have the potential to be effected by this practice.</p> <p>III. The Director of Maintenance's logs were updated to reflect that the emergency generator room battery backup lights are tested monthly for 30 seconds and annually for 90 minutes duration to ensure the light</p>	02/14/2013			

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	<p>provided with a battery operated emergency light which was not tested at the time of inspection, but the Maintenance Supervisor said the light did work. Based on review of Battery Operated Emergency light check list on 01/15/13 at 3:45 p.m. with the Maintenance Supervisor, it was not documented the emergency generator battery backup light was tested monthly for thirty seconds or annually for ninety minutes. Based on interview concurrent with record review, it was acknowledged by the Maintenance Supervisor the emergency generator battery backup light was tested, but they lacked documentation for the thirty second monthly and ninety minute annual tests.</p> <p>3.1-19(b)</p>		<p>would provide lighting during periods of power outages with specific locations to mark exact dates and times that testing is completed.</p> <p>IV.</p> <p>The Director of Maintenance or his designee will review Maintenance logs and report findings in the quarterly Quality Assurance meeting.</p> <p>V.</p> <p>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: February 14, 2013</p>		

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K0048 SS=E	<p>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 include the use of the K-class fire extinguisher in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 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 10 residents in the dining room adjacent to the kitchen as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire disaster plan on 01/15/13 at 3:45 p.m. with the Maintenance Supervisor, the fire disaster plan did not include the use of the K-class fire extinguisher located in the kitchen in relationship with the use of the</p>			K0048	<p>I. The facility Disaster Plan has been updated to include the use of the K – class fire extinguishers in the kitchen.</p> <p>II. All residents, visitors and staff have the potential to be effected by this practice.</p> <p>III. The Disaster Plan will be reviewed annually and updated as required.</p> <p>The Administrator will hold a staff education session on the updated Disaster Plan on February 6, 2013. The information will also be included in annual fire safety education sessions and with all new hire orientations.</p> <p>IV.</p>		02/14/2013

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	<p>kitchen overhead extinguishing system. Based on an interview on 01/15/13 at 3:47 p.m. with the Maintenance Supervisor, it was acknowledged the written fire safety plan for the facility did not include mention of the K-class fire extinguisher.</p> <p>3.1-19(b)</p>		<p>The Director of Maintenance or his designee will audit disaster/fire safety education and training events monthly and report findings to the Quality Assurance Committee.</p> <p>V.</p> <p>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: February 14, 2013.</p>		

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K0051 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 smoke detectors on 300 hall were installed in a location which would allow the smoke detector to function to its fullest capability. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 30 residents on 300 hall next to the Central nurse's station as well as visitors and staff.</p> <p>Findings include:</p>	K0051	<p>I. The smoke detector on 300-hall is scheduled to be replaced and relocated by the contracted alarm services company by the alleged date of compliance to ensure that the smoke detector will function to its fullest capability.</p> <p>II. All residents, visitors and staff have the potential to be effected by this practice.</p>	02/14/2013			

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	<p>Based on observation on 01/15/13 at 2:55 p.m. with the Maintenance Supervisor, the smoke detector next to the Central nurses' station on 300 hall was within six inches of an air diffuser in the ceiling.</p> <p>Based on interview on 01/15/13 at 2:56 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned smoke detector was installed within six inches of an air supply duct in the ceiling which would interfere with the smoke detector's ability to detect smoke to its fullest capability.</p> <p>3.1-19(b)</p>		<p>III.</p> <p>The Director of Maintenance or his designee observed all other smoke detectors in the facility for the same deficiency and no other deficiencies were noted. A review of smoke detectors in appropriate locations was included in the preventative maintenance monthly rounds.</p> <p>IV.</p> <p>The Director of Maintenance or his designee will review Maintenance logs and report findings in the quarterly Quality Assurance meeting.</p> <p>V.</p> <p>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: February 14, 2013</p>		

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K0062 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 dry automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.1. This deficient practice affects all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on review of Sprinkler system test reports on 01/15/13 at 4:02 p.m. with the Maintenance Supervisor, an internal inspection of the sprinkler system pipes had not been done. Based on interview on 01/15/13 at 4:04 p.m. with the Maintenance Supervisor, documentation could not be obtained to verify an internal sprinkler pipe inspection had been done in the last five years and no inspection has been scheduled.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 1 of 1</p>			K0062	<p>K062 (1)</p> <p>I. An internal pipe inspection is scheduled to be completed on February 8, 2013 by a contracted fire protection agency.</p> <p>II. All residents, visitors and staff have the potential to be effected by this practice.</p> <p>III. The Director of Maintenance's logs were updated to reflect that an internal pipe inspection is completed at minimum of every 5 years.</p> <p>IV. The Director of Maintenance or his designee will review Maintenance logs and report</p>		02/14/2013

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	<p>sprinkler heads observed in the kitchen storage room off of 100 hall which had paint on the fusible link. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler head shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect the 10 residents in the adjacent Main dining room as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 01/15/13 at 2:30 p.m. with the Maintenance Supervisor, the sprinkler head located in the kitchen storage room had paint on the glass fusible link. Based on interview on 01/15/13 at 2:31 p.m. with the Maintenance Supervisor, it was confirmed the sprinkler head located in the kitchen storage room had paint on the fusible link.</p> <p>3.1-19(b)</p>		<p>findings in the quarterly Quality Assurance meeting.</p> <p>V.</p> <p>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: February 14, 2013</p> <p>K062 (2)</p> <p>I.</p> <p>The sprinkler head located in the kitchen storage room will be replaced on February 8, 2013 by a contracted fire protection agency.</p> <p>II.</p> <p>All residents, visitors and staff have the potential to be effected by this practice.</p> <p>III.</p> <p>The Director of Maintenance or his designee observed all other sprinkler heads in the facility</p>		

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			<p>for the same deficiency and no other deficiencies were noted. A review of sprinkler heads for paint, corrosion, and damage was included in the preventative maintenance monthly rounds.</p> <p>IV.</p> <p>The Director of Maintenance or his designee will review Maintenance logs and report findings in the quarterly Quality Assurance meeting.</p> <p>V.</p> <p>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: February 14, 2013</p>		

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K0066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, record review and interview; the facility failed to ensure cigarette butts were deposited into a noncombustible container provided for 2 of 2 areas where smoking was permitted. This deficient practice could affect 24 residents on 100 hall and 30 residents on 300 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/15/13 during the tour between 1:15 p.m. and 3:05 p.m. with the Maintenance Supervisor, thirty</p>	K0066	<p>I.</p> <p>Metal containers with self-closing devices will be readily available in 2 of 2 smoking areas by February 8, 2013. Also, the facility smoking policy was revised to indicate that cigarette butts are to be deposited into non-combustible containers where smoking is permitted.</p>	02/14/2013	

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	gallon plastic trash containers used for paper goods in the two designated smoking areas just outside 100 hall and just outside the Assisted dining room were used for the disposal of fifty and thirty cigarette butts respectively. Based on review of the smoking policy on 01/15/13 at 4:32 p.m. with the Maintenance Supervisor, the smoking policy did address the proper disposal of extinguished cigarette butts. Based on interview on 01/15/13 at 3:38 p.m. with the Maintenance Supervisor, it was acknowledged the facility's employees disposed of cigarette butts into an unapproved plastic container with paper goods. 3.1-19(b)		<p>II. All residents, visitors and staff have the potential to be effected by this practice.</p> <p>III. The Director of Maintenance or his designee will observe all designated smoking areas for the same deficiencies five times weekly and rectify all areas of concern with immediate action.</p> <p>IV. The Director of Maintenance or his designee will report findings in the quarterly Quality Assurance meeting.</p> <p>V. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: February 14, 2013</p>		

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K0070 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to provide a portable space heater policy to regulate the use of 1 of 1 portable space heaters in nonresident rooms. This deficient practice could affect anyone visiting the Staff coordinator's office on Service hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/15/13 at 12:15 p.m. with the Maintenance Supervisor and Administrator, a portable space heater which was plugged in for use was located in the Staff coordinator's office on Service hall. Based on interview on 01/15/13 at 12:20 p.m., it was acknowledged by the Maintenance Supervisor and the Administrator, space heaters were not allowed, however, there was no written portable space heater policy addressing their use available.</p> <p>3.1-19(b)</p>	K0070	<p>I. The Director of Maintenance or his designee completed a tour of the building. Any and all portable space heaters were immediately removed from the facility.</p> <p>II. All residents, visitors and staff have the potential to be effected by this practice.</p> <p>III. It is the policy of this facility that no portable space heaters will be utilized in this facility. The Director of Maintenance or his designee will incorporate observations for portable space heaters into his monthly rounds for the same deficiency and rectify all areas of concern with immediate action. Additionally, the Administrator</p>	02/14/2013	

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			<p>will hold a staff education session on the facility's policy regarding portable space heaters on February 6, 2012.</p> <p>IV.</p> <p>The Director of Maintenance or his designee will report findings in the quarterly Quality Assurance meeting.</p> <p>V.</p> <p>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: February 14, 2013</p>		

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K0074 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation, record review and interview; the facility failed to ensure the window curtains in 34 of 52 resident rooms was maintained in a fire resistant condition. This deficient practice could affect 68 residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/15/13 during the tour between 12:45 p.m. and 4:00 p.m. with the Maintenance Supervisor, the window curtains installed in the following resident room lacked attached documentation confirming they were inherently flame resistant: Room</p>			K0074	<p>I. All window curtains in the facility are scheduled to be treated with a fire resistant solution by the alleged date of compliance.</p> <p>II. All residents, visitors and staff have the potential to be effected by this practice.</p> <p>III.</p>		02/14/2013

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	<p>numbers 101, 102, 103, 104 105, 106, 107, 108, 109, 110, 201, 202, 203, 205, 206, 207, 208, 209, 210, 212, 301, 303, 304, 305, 306, 307, 308, 310, 311, 312, 409, 410, 411 and 412. Based on record review on 01/15/13 at 4:35 p.m., the Maintenance Supervisor was unable to provide any documentation to verify the aforementioned window curtains were inherently flame resistant or that a fire resistant solution had ever been applied to them. Based on interview on 01/15/13 at 4:37 p.m. with the Maintenance Supervisor, it was acknowledged there was no documentation regarding the fire resistance of the window curtains or the application of a flame resistance solution to the curtains.</p> <p>3.1-19(b)</p>		<p>The Director of Maintenance or his designee will incorporate a schedule to maintain and treat all facility window curtains in such a way that will meet the user guidelines of the fire resistant solution on a monthly basis and document that such actions were completed in the designated area of the maintenance logs.</p> <p>IV.</p> <p>The Director of Maintenance or his designee will report findings in the quarterly Quality Assurance meeting.</p> <p>V.</p> <p>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: February 14, 2013</p>	

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K0143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transfer occurs had a working light inside the room so staff can work safely after the door has been closed. This deficient practice could affect 24 residents on 100 hall as well as visitors and staff in the area.</p> <p>Findings include:</p> <p>Based on observation on 01/15/13 at 2:46 p.m. with the Maintenance Supervisor, the oxygen storage room on 100 hall used to store and transfer oxygen was provided with one light fixture but it was not working. Based on interview on 01/15/13 at 2:50 p.m., it was acknowledged by the</p>	K0143	<p>I. The light bulb in the oxygen storage room was immediately replaced with a working light-bulb on January 15, 2013.</p> <p>II. All residents, visitors and staff have the potential to be effected by this practice.</p> <p>III. No other rooms are used for the storage or transferring of</p>	02/14/2013			

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	the Maintenance Supervisor this room was used to transfer oxygen and though it had a light fixture, it was not working at the time of inspection. 3.1-19(b)		<p>oxygen. The Director of Maintenance or his designee will include the oxygen storage room in the preventative maintenance monthly rounds.</p> <p>IV.</p> <p>The Director of Maintenance or his designee will report findings in the quarterly Quality Assurance meeting.</p> <p>V.</p> <p>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: February 14, 2013</p>		

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K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all</p>			K0144	<p>I. Another load test will be completed on January 31, 2013 by an approved regulation method.</p> <p>II. All residents, visitors and staff have the potential to be effected by this practice.</p> <p>III. The Director of Maintenance or his designee will continue to perform monthly load testing in accordance with state regulation.</p> <p>IV. The Director of Maintenance or his designee will report findings in the quarterly Quality Assurance meeting.</p>		02/14/2013

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	<p>residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Generator System Testing records and Maintenance logs on 01/15/13 at 4:38 p.m. with the Maintenance Supervisor, there was no documentation which verified the the amperage or the percentage of load capacity for the past twelve months.</p> <p>Based on interview on 01/15/13 at 4:40 p.m. with the Maintenance Supervisor, it was acknowledged the facility had no documentation to verify amperage or percentage of load capacity for the past twelve months.</p> <p>3.1-19(b)</p>		<p>V.</p> <p>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: February 14, 2013</p>		