

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155532	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/13/2015
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NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401
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K 0000 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: 07/13/15</p> <p>Facility Number: 000460 Provider Number: 155532 AIM Number: 100290620</p> <p>At this Life Safety Code survey, Bloomington Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 38</p>	K 0000	<p>Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204</p> <p>July, 27, 2015</p> <p>Dear Ms. Rhoades,</p> <p>A Life Safety Code Survey was conducted at our facility on July 13, 2015.</p> <p>By submitting the enclosed material we are not admitting the truth or accuracy of specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of corrections be considered our allegation of compliance effective June 30, 2015 to the annual licensure survey conducted on July 13, 2015. We respectfully request a paper review. We will provide you with any additional information to confirm compliance per your request.</p> <p>Respectfully,</p> <p>Mark Thompson, HFA Administrator</p>	
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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 0018 SS=E Bldg. 01	<p>and had a census of 33 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two detached sheds used for facility storage.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 18 resident room corridor doors would close and latched into the door frame. This deficient practice could affect any number of residents while in the corridor outside room 1.</p> <p>Findings includes:</p> <p>Based on observation on 07/13/15 at</p>	K 0018	<p>K 018 NFPA101 Life Safety Code Standard</p> <p><u>What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice:</u> The door to room # 1 has been repaired.</p> <p><u>How otherresidents having the potential to be affected by the</u></p>	07/28/2015

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	<p>11:40 a.m. during a tour of the facility with the Administrator, resident room 1 door would not close and latch into the door frame. The door stayed open one inch. This was acknowledged by the Administrator at the time of observation.</p> <p>3.1-19(b)</p>		<p><u>same deficient practice will be identified and what corrective action will be taken:</u> An audit of all room doors has been conducted to review for any other doors that need repaired. The audit revealed no other doors in need of repair at this time.</p> <p><u>What measures will be put in place or what systemic change will be made to ensure the deficient practice does not recur:</u> A door check off sheet has been created and In-service with Maintenance Technician has been conducted. This door check off sheet will be used to ensure that doors are working correctly.</p> <p><u>How the Corrective Action will be monitored to ensure the deficient practice will not recur, ie: what quality assurance program will be put in place:</u> The Door check off sheet will be used 1x per week for 30 days and monthly thereafter. This check off sheet will be brought to the daily Q.A. meetings. Issues will be reviewed and appropriate action taken. Administrator will utilize Administrator rounds checklist 1 day per week for 30 days and then 1x per month for 6 months. Results of this audit will be reviewed at Quality Assurance Meetings.</p> <p><u>By what date the systemic changes will be completed:</u> 08/12/2015</p>	

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K 0038 SS=F Bldg. 01	<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 observation and interview, the facility failed to ensure the means of egress through 3 of 3 locked emergency exits were readily accessible for residents and visitors. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 07/13/15 between 11:30 a.m. and 12:45 p.m. during a tour of the facility with the Administrator, all three emergency exit doors were magnetically locked and could be opened by entering a code on a keypad located adjacent to the exit doors. The code was not posted at any of the three emergency exit doors. This was acknowledged by the Administrator at the time of each observation. During an interview at 12:30 p.m., the Administrator indicated residents in the facility where a mixed population of alert and cognitively impaired residents.</p>	K 0038	<p>K 038 NFPA101 Life Safety Code Standard</p> <p><u>What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice:</u> The codes to the three exit doors have been posted as the monthand year. <u>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action will be taken:</u> The action taken ensures that all residents will no longerbe affected by the deficiency cited. <u>What measures willbe put in place or what systemic change will be made to ensure the deficientpractice does not recur:</u> A door check off sheet has been created and In-service withMaintenance Technician has been conducted. This door check off sheet will beused to ensure that doors are working correctly.</p>	07/28/2015

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K 0046 SS=C Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1. Based on record review and interview, the facility failed to ensure 12 of 12 battery operated emergency lights in the facility were maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting</p>	K 0046	<p><u>How the Corrective Action will be monitored to ensure the deficient practice will not recur, ie; what quality assurance program will be put in place:</u> The Door check off sheet will be used 1x per week for 30 days and monthly thereafter. This check off sheet will be brought to the daily Q.A. meetings. Issues will be reviewed and appropriate action taken. Administrator will utilize Administrator rounds checklist 1 day per week for 30 days and then 1x per month for 6 months. Results of this audit will be reviewed at Quality Assurance Meetings.</p> <p><u>By what date the systemic changes will be completed:</u> 08/12/2015</p> <p>K 046 NFPA 101 Life Safety Code Standard</p> <p><u>What corrective action will be accomplished for those residents found to have been affected by the deficient</u></p>	07/28/2015

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	<p>Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors throughout the facility.</p> <p>Findings include:</p> <p>Based on review of the Emergency Battery Powered Spot Lights in the PM Program book and the Battery Back Up Lights in the Life Safety book on 07/13/15 at 10:25 a.m. with the Administrator present, the facility has a total of twelve battery powered spot lights and battery back up light/exit light combos. The only testing documentation available for all twelve light sets was dated 06/25/15, additionally, the only testing documentation available for just the six battery powered spot lights was 04/30/15 and 05/21/15. Furthermore, the most recent ninety minute testing documentation for all twelve light sets was dated 05/21/14, which was over</p>		<p><u>practice:</u> The Emergency Battery Powered Spot Lights and the BatteryBack Up Lights are a part of our PM program. We will continue to use the sameform. They have been inspected and found to be working properly. This facilityhas hired a new Maintenance Technician to complete these inspections perregulations. <u>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action will be taken:</u> The Emergency Battery Powered Spot Lights and Battery BackUp lights affect all residents. They have been inspected and were found to be working properly. <u>What measures willbe put in place or what systemic change will be made to ensure the deficientpractice does not recur:</u> The new Maintenance Technician has been trained and hasexperience with the Preventive Maintenance Program. From this day forward theywill complete the Inspections per the PM Program. <u>How the CorrectiveAction will be monitored to ensure the deficient practice will not recur, ie;what quality assurance program will be put in place:</u> The 30 minute Inspections will be completed on a monthlybasis and 90 minutes annually. The Administrator will participate in</p>				

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K 0050 SS=F Bldg. 01	<p>twelve months ago. This was confirmed by the Administrator at the time of record review.</p> <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. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 2 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents in the facility.</p>	K 0050	<p>monthly inspections each month for 6 months. The Maintenance Technician will provide Administrator with copy of 30 minute inspection form each month thereafter. The Maintenance will provide a copy of the annual inspection. Results of inspections will be reviewed at Quality Assurance Meetings.</p> <p><u>By what date the systemic changes will be completed:</u> 08/12/2015</p> <p>K 050 NFPA 101 Life Safety Code Standard</p> <p><u>What corrective action will be accomplished for those residents found to have been</u></p>	07/28/2015

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	<p>Findings include:</p> <p>Based on review of the facility's fire drills in the Life Safety book on 07/13/15 at 9:45 a.m. with the Administrator present, the facility lacked written documentation fire drills were conducted during the following shifts and quarters:</p> <p>a. Second shift (evening) of the first quarter (January, February, March), and second quarter (April, May, and June) of 2015.</p> <p>b. Third shift (night) of the second quarter (April, May, and June) of 2015 This was confirmed by the Administrator at the time of record review.</p> <p>3.1-19(b)</p>		<p><u>affected bythe deficient practice:</u> A Fire Drill was conducted and scheduled to be conductedmonthly per facility Policy. By doing Drills monthly we will meet the quarterlyguidelines. This facility has hired a new Maintenance Technician to completethese Drills per regulations.</p> <p><u>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action will be taken:</u> Fire Drills affect all residents. A Fire Drill was conductedand scheduled to be conducted monthly per facility Policy. By doing Drillsmonthly we will meet quarterly guidelines. The facility has hired a new Maintenancetechnician to complete these Drills per regulations.</p> <p><u>What measures willbe put in place or what systemic change will be made to ensure the deficientpractice does not recur:</u> The new Maintenance Technician has been trained and hasexperience with the Fire Drill Policy.. From this day forward they willcomplete these Fire Drills monthly per the PM Program.</p> <p><u>How the CorrectiveAction will be monitored to ensure the deficient practice will not recur. ie;what quality assurance</u></p>		

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K 0052 SS=C Bldg. 01	<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>Based on record review and interview, the facility failed to ensure the documentation for the sensitivity testing of 10 of 12 smoke detectors was complete. LSC 9.6 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors be tested annually. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p>	K 0052	<p><u>program will be put in place:</u> The Fire Drills will be completed on a monthly basis. The Administrator will participate in monthly Drills each month for 6 months. The Maintenance Technician will provide Administrator with copy of Fire Drill for each month thereafter. Results of the Drills will be reviewed at Quality Assurance Meetings.</p> <p><u>By what date the systemic changes will be completed:</u> 08/12/2015</p> <p><u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</u> The Vendor used to do the required Sensitivity was contacted and they will modify the inspection form so that it shows the alarm point and sensitivity range. Our facility has hired a</p>	07/28/2015			

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	<p>Findings include:</p> <p>Based on review of the facility's sensitivity testing report in the Life Safety book on 07/13/15 at 9:55 a.m. with the Administrator present, the most recent sensitivity testing report dated 04/02/15 did not include the alarm point or sensitivity range to verify the testing of each smoke detector fell within the sensitivity range for 10 smoke detectors, however, all smoke detectors were marked as having passed the sensitivity test. The Safe Care "Sensitivity Test and Inspection" report showed "Factory Setting" (Sensitivity Range) as "Green=Pass" with the "Measured Setting" (Alarm Point) as "Green" for 10 of the 12 smoke detectors. During an interview at the time of record review, the Administrator acknowledged there was no sensitivity range listed for 10 of 12 smoke detectors on the 04/02/15 report.</p> <p>3-1.19(b)</p>		<p>new Maintenance Technician to oversee these Inspections per regulations.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</u> Sensitivity Testing and Inspections affect all residents. The Inspection will continue to be conducted per regulations. The facility has hired a new Maintenance technician to oversee these Inspections per regulations.</p> <p><u>What measures will be put in place or what systemic change will be made to ensure the deficient practice does not recur:</u> The new Maintenance Technician has been trained and has experience with Life Safety Inspections. From this day forward the Inspections will be reported with the alarm point and sensitivity range per regulations.</p> <p><u>How the Corrective Action will be monitored to ensure the deficient practice will not recur, ie: what quality assurance program will be put in place:</u> The Sensitivity Testing will continue to be completed annually. The Maintenance Technician and Administrator will participate in an exit meeting with the Vendor. Action will be taken immediately for issues identified in the report. Findings of</p>	

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K 0062 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. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review, observation and interview; the facility failed to ensure sprinkler heads in 3 of 3 smoke compartments were free of paint and corrosion. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be free of paint or corrosion. Any sprinkler shall be replaced that is painted or corroded. This deficient practice could affect any number of residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's quarterly sprinkler system inspections in the Life Safety book on 07/13/15 at 10:10 a.m.</p>	K 0062	<p>these inspections will be discussed in Q.A. meetings quarterly. <u>By what date the systemic changes will be completed:</u> 08/12/2015</p> <p>K 062 NFPA 101 Life Safety Code Standard <u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</u> The 3 sprinkler heads with corrosion located in the Kitchen; Sprinkler Head with paint in rooms 14, 16, 17, 18; 1 corroded sprinkler head in bathroom 4; 1 sprinkler head with paint in Activity Storage closet; and 1 sprinkler head with paint in Laundry room have been quoted for repair after they were identified June 3, 2015. This repair has been scheduled to be completed on July 27, 2015. Our facility has hired a new Maintenance Technician and he will oversee that the repairs are completed. <u>How other residents having the potential to be affected by the same deficient</u></p>	07/28/2015

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K 0066 SS=E	<p>with the Administrator present, the Safe Care quarterly sprinkler system inspection report dated 06/03/15 had a list of sprinkler heads throughout the facility with paint or corrosion. Based on observations between 11:30 a.m. and 12:45 p.m. during a tour of the facility with Administrator, the following locations had sprinkler heads with paint or corrosion:</p> <ul style="list-style-type: none"> a. Kitchen - 3 sprinkler heads with corrosion b. Resident Room 14 - one sprinkler head with paint c. Resident Room 16 - two sprinkler heads with paint d. Resident Room 17 - one sprinkler head with paint e. Resident Room 18 - two sprinkler heads with paint f. Bathroom #4 - one sprinkler head with corrosion g. Activity Storage closet - one sprinkler head with paint h. Laundry room - one sprinkler head with paint <p>This was acknowledged by the Administrator at the time of each observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		<p><u>practicewill be identified and what corrective action will be taken:</u> Sprinkler system Inspections affect all residents. Theinspection will continue to be conducted per regulations. The facility has hired a new Maintenance technician to oversee these Inspections perregulations. <u>What measures willbe put in place or what systemic change will be made to ensure the deficientpractice does not recur:</u> The new Maintenance Technician has been trained and hasexperience with Life Safety Inspections. Our facility will continue to useSafeCare for quarterly Inspections. Areas identified that need repairs duringthese Inspections will be promptly corrected. <u>How the CorrectiveAction will be monitored to ensure the deficient practice will not recur, ie;what quality assurance program will be put in place:</u> Sprinkler Inspections will continue to be completedquarterly. The Maintenance Technician and Administrator will participate in anexit meeting with the Vendor. Action will be taken immediately for issuesidentified in the report. Findings will be discussed in Q.A .quarterly. <u>By what date the systemic changes will be completed:</u> 08/12/2015</p>	

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NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401
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Bldg. 01	<p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 1 areas where cigarettes were smoked. This deficient practice could affect any number of residents, as well as staff and visitors at a time while in the smoking area.</p> <p>Findings include:</p> <p>Based on observation on 07/13/15 at 12:35 p.m. during a tour of the facility with the Administrator, there was a metal cigarette butt container in the smoking</p>	K 0066	<p>K 066 NFPA101 Life Safety Code Standard</p> <p><u>What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice:</u></p> <p>The Cigarette butt container was cleaned out and all papertrash removed. A sign stating this is for cigarette butts only was attached tothe container to help alert those trying to dispose of paper trash. The trashcontainer for paper trash only was cleaned out to remove cigarette butts.</p> <p><u>How otherresidents having the</u></p>	07/28/2015

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	<p>structure. The metal container contained a mixture of cigarette butts and paper trash. Furthermore, there was a trash container outside the smoking structure which also contained a mixture of cigarette butts and paper trash. This was acknowledged by the Administrator at the time of observation.</p> <p>3.1-19(b)</p>		<p><u>potential to be affected by the same deficient practicewill be identified and what corrective action will be taken:</u> The improper use of these containers, affect all residents. The facility has hired a new Maintenance technician to oversee Life Safety. The Daily Mechanical Inspection form that Maintenance uses has been modified to include the task of checking cigarette and trash containers. The Housekeeping checklist for facility has been modified to include the task of checking cigarette and trash containers. <u>What measures will be put in place or what systemic change will be made to ensure the deficient practice does not recur:</u> The new Maintenance Technician has been trained and has experience with Life Safety PM program. Maintenance Technician will use the modified Daily Mechanical Inspection form. The Housekeeping checklist for facility has been modified to include the task of checking cigarette butts and trash containers. Facility employees have been in-serviced on proper use of trash and cigarette butt containers. <u>How the Corrective Action will be monitored to ensure the deficient practice will not recur, ie; what quality assurance program will be put in place:</u></p>	

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K 0069 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in	K 0069	Maintenance inspection form and Housekeeping checklist will be turned in to Administrator 5 days per week. Findings will be discussed in Q.A. quarterly. <u>By what date the systemic changes will be completed:</u> 08/12/2015 K 069 NFPA 101 Life Safety Code Standard <u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</u> The semiannual inspection for the kitchen range hood had been conducted in October 2014 but it was not with the other inspections at time of survey. It is now in the Binder with the Inspection from April. <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</u> The facility has hired a new Maintenance Technician and	07/28/2015

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K 0130 SS=F	<p>accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect mostly kitchen staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the kitchen range inspection reports in the Life Safety book on 07/13/15 at 10:20 a.m. with the Administrator present, there was no documentation available to show the kitchen range hood had been inspected semiannually during the past twelve months. The only inspection document available was dated 04/09/15. The previous inspection report was dated 04/14. This was confirmed by the Administrator at the time of record review.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS</p>		<p>hehas been trained and is experienced with Life Safety. He has organized the LifeSafety Binder and reviewed to ensure all required inspections are up to date.</p> <p><u>What measures willbe put in place or what systemic change will be made to ensure the deficientpractice does not recur:</u></p> <p>The new Maintenance Technician has been trained and hasexperience with Life Safety PM Program. Maintenance Technician will use the PM program to ensure we are in Compliance.</p> <p><u>How the CorrectiveAction will be monitored to ensure the deficient practice will not recur, ie;what quality assurance program will be put in place:</u></p> <p>The Maintenance Technician will participate in the exitmeeting after the semiannual kitchen range hood inspections. A copy of thisreport will be provided to the Administrator immediately.</p> <p>Findings will be discussed in Q.A .quarterly.</p> <p><u>By what date the systemic changes will be completed:</u> 08/12/2015</p>		

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Bldg. 01	<p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review, interview and observation; the facility failed to ensure the proper maintenance of 18 of 18 battery operated smoke detectors in resident rooms to ensure the smoke detectors are continually operable. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice could all residents, as well as staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the PM Program book and the Life Safety book on 07/13/15 at 11:15 a.m. with the Administrator present, all 18 resident sleeping rooms have battery operated smoke alarms. There was no documentation available to show any of the battery operated smoke alarms have been inspected/tested monthly over the past twelve months. This was confirmed by the Administrator at the time of record review. Based on observation between 11:30 a.m. and 12:45 p.m. it was confirmed all resident rooms were provided with battery operated smoke alarms.</p> <p>3.1-19(b)</p>	K 0130	<p>K 130 NFPA 101 Life Safety Code Standard</p> <p><u>What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice:</u> An Inspection of the Smoke Detectors was conducted andscheduled to be conducted monthly per facility Policy. By doing Inspections monthlywe will meet the monthly guidelines. This facility has hired a new MaintenanceTechnician to complete these Inspections per regulations.</p> <p><u>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action will be taken:</u> Smoke Detectors affect all residents. An Inspection wasconducted and scheduled to be conducted monthly per facility Policy. By doinginspections monthly we will meet monthly guidelines. The facility has hired anew Maintenance technician to complete these Inspections per regulations.</p> <p><u>What measures willbe put in place or what systemic change will be made to ensure the deficientpractice does not recur:</u> The new Maintenance Technician has been trained and</p>	07/28/2015

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			<p>has experience with the Smoke Detector Inspection Policy.. From this day forward they will complete these Inspections monthly per the PM Program and Stateregulations.</p> <p><u>How the Corrective Action will be monitored to ensure the deficient practice will not recur, ie; what quality assurance program will be put in place:</u></p> <p>The Inspections will be completed on a monthly basis. The Administrator will participate in monthly Drills each month for 6 months. The Maintenance Technician will provide Administrator with copy of Inspections for each month thereafter. Results of the Inspections will be reviewed at Quality Assurance Meetings.</p> <p><u>By what date the systemic changes will be completed:</u> 08/12/2015</p>	