

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2014
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NAME OF PROVIDER OR SUPPLIER EAGLE VALLEY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214
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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: 03/24/14</p> <p>Facility Number: 000188 Provider Number: 155291 AIM Number: 100266310</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Eagle Valley Meadows 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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping</p>	K010000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey Review on or after 04/18/14.	
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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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	<p>rooms. The facility has a capacity of 115 and had a census of 101 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building, a wooden storage shed, providing facility services which was not sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010025 SS=F	<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 observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or 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 all residents, staff and visitors if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:30 p.m. to 3:00 p.m. on</p>	K010025	<p>K-025 Smoke Barriers It is the intent of this provider to ensure smoke barriers are constructed to provide at least 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 notrequired in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioner systems. What corrective actions will be accomplished for those found to have been affectedby the alleged deficient practice? The one inch space surrounding the sprinkler pipe in C Wing storage was closedusing fire caulk. The hole for thecables was closed using fire caulk. The three inch hole in the main fire panel room was closed using fire caulk. The</p>	04/18/2014	

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	<p>03/24/14, the following openings were noted in the ceiling smoke barrier:</p> <p>a. the one inch annular space surrounding a two inch in diameter sprinkler pipe in the C Wing Storage Room.</p> <p>b. the two inch annular space surrounding a three inch in diameter conduit in the mechanical room by the C Wing Storage Room was filled with foam which is not an approved material for maintaining the fire resistance of a smoke barrier. In addition, a one inch in diameter hole for the passage of ten cables was noted in the aforementioned storage room.</p> <p>c. a three inch in diameter hole for three conduits in the Main Fire Panel Room.</p> <p>d. a one inch in diameter hole for one conduit in the emergency generator room.</p> <p>e. a three inch long by two inch wide hole for two conduits in the Soiled Laundry Room.</p> <p>f. a one inch hole by the sprinkler escutcheon in the Central Supply storage room.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged each of the aforementioned openings failed to maintain the fire resistance of the ceiling smoke barrier.</p> <p>3.1-19(b)</p>		<p>one inch hole the emergency generatorroom was closed using fire caulk. Fire caulk was used to close the three inch hole in the soiled laundry room. The one inch hole by the sprinkler escutcheonin the central supply room was filled using fire caulk. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All residents have the potential to be affected by the deficient practice. The Maintenance Director will observe smoke barriers for areas of penetration and the smoke barrier shall be filled with material capable of maintaining smoke resistance. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur? The Maintenance Director and assistant will be educated on smoke barriers before 4/18/14. The Maintenance Director will observe for penetration to smoke barriers during routine weekly maintenance checks. How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? The Maintenance Director/designee with be responsible to complete the Life Safety Review CQI weekly for four weeks, bi-weekly for two months and monthlythereafter.</p>				

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			The results of these audits will be reviewed by the CQI committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Date of compliance 04/18/14		

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K010029 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>1. Based on observation and interview, the facility failed to ensure 1 of 1 soiled linen storage areas were in an enclosure protected as a hazardous area and having smoke resistant partitions and doors. This deficient practice could affect 20 residents, staff or visitors in the vicinity of the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:30 p.m. to 3:00 p.m. on 03/24/14, eight mobile soiled linen receptacles each contained soiled linen and were unattended and stored next to each other in the service corridor outside the Laundry. Based on interview at 1:45 p.m., the Maintenance Director stated each mobile soiled linen receptacle was less than 32 gallon capacity, the eight</p>	K010029	<p>K029 – Egress Doors It is the intent of this provider to ensure 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.</p> <p>What corrective actions will be accomplished for those found to have been affected by the alleged deficient practice? The eight mobile soiled linen receptacles were moved out of the storage hallway. The holes in the ceiling of the laundry room and the central supply room were</p>	04/18/2014	

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	<p>carts together totaled more than 32 gallons and acknowledged soiled linen and trash receptacles with more than 32 gallons capacity were not stored in an area protected as a hazardous area and having smoke resistant partitions and doors.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure ensure 2 of 11 hazardous areas such as soiled linen rooms and storage rooms for combustibles over 50 square feet in size were separated from other spaces by smoke resistant partitions. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the service corridor.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:30 p.m. to 3:00 p.m. on 03/24/14, a three inch long by two inch wide hole in the ceiling of the Soiled Laundry Room and a one inch hole in the ceiling of the Central Supply storage room by the sprinkler escutcheon was noted which did not separate these hazardous areas from other spaces by smoke resistant partitions. Based on</p>		<p>repaired. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All residents in the vicinity of the service hallway have the potential to be affected by the deficient practice. The Laundry Supervisor will ensure soiled linen is stored in an area with smoke resistant partitions and or doors and away from combustibles. The Maintenance Director will ensure hazardous areas are separated by smoke resistant partitions. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur? The laundry staff, Maintenance Director and assistant will be educated on soiled linen storage by 4/18/14. The Laundry Supervisor/designee will ensure laundry is properly stored daily. The Maintenance Director will observe for penetration to smoke barriers and partitions during routine weekly maintenance checks. How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? The Maintenance Director/designee will be responsible to complete the Life Safety Review CQI weekly for four weeks, bi-weekly for two months and monthly thereafter. The</p>		

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	<p>interview at the time of the observations, the Maintenance Director acknowledged the holes in the ceiling of the aforementioned hazardous areas did not separate these areas from other spaces by smoke resistant partitions.</p> <p>3.1-19(b)</p>		<p>Laundry Supervisor/designee will complete the Environmental Safety – Laundry CQI weekly for four weeks, bi-weekly for two months, and monthly thereafter. The results of these audits will be reviewed by the CQI committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Date of compliance 04/18/14</p>	

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K010038 SS=E	<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>1. Based on observation and interview, the facility failed to ensure the means of egress through 2 of 7 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a</p>	K010038	<p>K-038Exit access It is the intent of the provider that exit access is arranged so that exits are readily accessible at all times in accordance with 7.1 19.2.1 What corrective actions will be accomplished for those found to have been affected by the alleged deficient practice? Integrated Electronics was contacted and repaired the egress lock on the door by room 136 andthe exit door in therapy gym on 4/3/14. A sign was ordered for the exit door in the main dining room on 4/2/14. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All residents in the vicinity of the main dining room, therapy gym and B hall have the potential to be affected by the deficient practice. The Maintenance Director will be responsible to ensure that exit signs are marked and egress locks are functioning properly. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur? The Maintenance Director will check magnetic egress locks weekly during preventative maintenance rounds to ensure function. How the</p>	04/18/2014
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	<p>delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS. This deficient practice could affect 50 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:30 p.m. to 3:00 p.m. on 03/24/14, the following was noted:</p> <p>a. the exit door by Room 136 to the exterior of the building is marked as a facility exit, is equipped with a delayed egress lock and provided with signage stating the door could be opened in 15 seconds by pushing on the door release device, but the exit door did not release within 15 seconds when the door was pushed with the application of force three separate times. A timer was used to determine the aforementioned exit door released 29 seconds after pushing on the door each of the three separate times.</p> <p>b. the exit door from the Main Dining Room to the exterior of the building is</p>		<p>corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? The Maintenance Director/designee with be responsible to complete the Environmental Safety – Hallways and Day room areas CQI weekly for four weeks, bi-weekly for two months and quarterly thereafter. The results of these audits will be reviewed by the CQI committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Date of compliance? 04/18/14</p>		

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	<p>marked as a facility exit, is equipped with a delayed egress lock, but is not posted with signage stating the door could be opened in 15 seconds with the application of force. The aforementioned exit door released within 15 seconds when pushed three separate times.</p> <p>Based on interview at the time of the observations, the Maintenance Director stated the aforementioned exit doors are each a facility exit, each exit door is equipped with a delayed egress lock and acknowledged the exit door by Room 136 did not release within 15 seconds and the Main Dining Room exit door did not have signage posted indicating the door would release when pushed with the application of force.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 9 exit door electromagnetic locks remained unlocked while the fire alarm was activated. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.2(e) states activation of the building automatic sprinkler or fire detection system, if provided, automatically unlocks the doors and the doors remain unlocked until the fire</p>			
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	<p>protective signaling system has been manually reset. This deficient practice could affect 10 residents, staff and visitors needing to exit the building from the Therapy Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility on 03/24/14, the electromagnetic lock on the Therapy Room exit door did not release and remain unlocked when the fire alarm was activated at 2:48 p.m. Based on interview at the time of observation, the Maintenance Director acknowledged the electromagnetic lock on the Therapy Room exit door did not release when the fire alarm system was activated.</p> <p>3.1-19(b)</p>			
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K010046 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 record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 14 of 14 battery powered lights during the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds 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.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Emergency Lights-Test Log for 2013 and 2014" documentation with the Maintenance Director during record review from 9:35 a.m. to 11:50 a.m. on 03/24/14, the following was noted: a. documentation of functional testing for</p>	K010046	<p>K046– Emergency Lighting It is the intent of the provider to ensure emergency lighting of at least 1.5 hour duration is provided in accordance with 7.9 19.2.9.1 What corrective actions will be accomplished for those found to have been affected by the alleged deficient practice? The therapy wing lights were listed on the test log for 2014. The light located in the main fire panel room was replaced and the annual test was completed. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All residents have the potential to be affected by the deficient practice. The Battery operated emergency test log was updated to include the lights in therapy for the year 2014. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur? The log was updated to include all emergency lights. The Maintenance Director will complete themonthly preventative maintenance on the battery operated emergency lights monthly and complete the monthly Preventative Maintenance documentation and</p>	04/18/2014			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>not less than 30 seconds for 4 of 14 battery operated emergency lights for January and February 2014 was not available for review. The aforementioned test logs had documented monthly functional testing of four Therapy Wing battery operated emergency lights in 2013 but the four Therapy Wing lights were not listed on the test log for 2014.</p> <p>b. documentation of an annual test for 14 of 14 battery powered emergency lights for at least a 1 ½ hour duration for the most recent twelve month period was not available for review.</p> <p>Based on observations with the visiting Maintenance Director during a tour of the facility from 12:30 p.m. to 3:00 p.m. on 03/24/14, a total of fourteen battery operated emergency lights were located in the facility which included four lights in the Therapy Wing. Each battery operated emergency light operated when their respective test button was pushed except for the light located in the Main Fire Panel Room which did not function when its test button was pushed five times. Based on interview at the time of record review and of the observations, the Maintenance Director acknowledged fourteen battery operated emergency lights were located in the facility, the light located in the Main Fire Panel Room failed to operate and documentation of an annual ninety</p>		<p>the log. How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? The Maintenance Director/designee with be responsible to complete the Life SafetyReview CQI weekly for four weeks, bi-weekly for two months and monthly thereafter. The results of these audits will be reviewed by the CQI committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Date of compliance 04/18/14</p>		

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	<p>minute test and complete monthly functional testing documentation for the most recent twelve month period for all battery operated emergency lights was not available for review.</p> <p>3.1-19(b)</p>			
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K010050 SS=F	<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>1. Based on record review and interview, the facility failed to document fire drills conducted on the second shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Report" with the Maintenance Director during record review from 9:35 a.m. to 11:50 a.m. on 03/24/14, documentation of a fire drill conducted on the second shift for the fourth quarter of 2013 was not available for review. Based on interview at the time of record review, the Maintenance Director stated no other fire drill documentation was available for review and acknowledged documentation of a fire drill conducted on the second shift for the fourth quarter of 2013 was not available for review.</p>	K010050	<p>K050 – Fire Drills It is the intent of this provider to hold fire drills 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 9pm and 6am a coded announcement may be used instead of audible alarms. 19.7. 1.2 What corrective actions will be accomplished for those found to have been affected by the alleged deficient practice? A fire drill was held on the second shift on 4/4/14. The transmission of the fire alarm signal was verified with the alarm company. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All residents</p>	04/18/2014	

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	<p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to document activation of the fire alarm system for fire drills conducted between 6:00 a.m. and 9:00 p.m. on the second shift for 2 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Report" with the Maintenance Director during record review from 9:35 a.m. to 11:50 a.m. on 03/24/14, documentation for second shift fire drills conducted on 05/30/13 at 5:10 p.m. and on 08/30/13 at 7:30 p.m., each conducted after 6:00 a.m. but before 9:00 p.m., did not include transmission of the fire alarm signal. Each of the aforementioned second shift fire drill reports stated "No" in response to "Was action taken to activate the fire alarm system?" and "Was it verified that</p>		<p>have the potential to be affected by the deficient practice. The Maintenance Director and assistant will be educated on fire drills by 4/18/14. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur? The Maintenance Director will ensure fire drills are held according to the Fire Drill Shift/Time Stagger schedule. The alarm system will be activated during normal operating hours. The alarm company will provide documentation to the Maintenance Director to show the system activation.</p> <p>The Maintenance Director will complete the Monthly fire drill report. How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? The Maintenance Director/designee will be responsible to complete the Life Safety Review CQI weekly for four weeks, bi-weekly for two months and monthly thereafter. The results of these audits will be reviewed by the CQI committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Date of compliance 04/18/14</p>		

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	<p>the Monitoring Service received the alarm?" Based on interview at the time of record review, the Maintenance Director acknowledged documentation for the aforementioned second shift fire drills conducted after 6:00 a.m. and before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 3 of 4 quarters. This deficient practice affects all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Director during record review from 9:35 a.m. to 11:50 a.m. on 03/24/14, third shift fire drills conducted on 03/28/13, 06/27/13 and 11/29/13 were conducted at, respectively, 11:12 p.m., 11:30 p.m. and 10:30 p.m. Based on interview at the time of record review, the Maintenance Director acknowledged third shift fire drills were not conducted at unexpected times under varying</p>				

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K010062 SS=C	<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 observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director at 1:30 p.m. on 03/24/14, sidewall spare sprinklers were</p>	K010062	<p>K062 – Sprinklers It is the intention of the provider to ensure there is an automatic sprinkler system that is continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6 4.6 12, NFPA 13, NFPA 259.7.5 What corrective actions will be accomplished for those found to have been affected by the alleged deficient practice? Sidewall sprinklers were ordered for the facility. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All residents residing on C Hall have the potential to be affected by the deficient practice. The Maintenance Director will be responsible to ensure spare sprinklers are available. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur? The Maintenance Director will check the sprinkler system weekly and ensure the spare sprinklers are available. How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality</p>	04/18/2014

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	<p>not located in the spare sprinkler cabinet in the sprinkler riser room in the kitchen. During a tour of the facility with the Maintenance Director from 12:30 p.m. to 3:00 p.m. on 03/24/14, sidewall sprinklers were installed in the C Wing Dining Room. Based on interview at the time of the observations, the Maintenance Director acknowledged sidewall sprinklers were installed in the facility and no spare sidewall sprinklers were located in the spare sprinkler cabinet or on the premises.</p> <p>3.1-19(b)</p>		<p>assurance program will be put into place? The Maintenance Director/designee with be responsible to complete the Environmental Safety – Maintenance and Storage Area CQI weekly for four weeks, bi-weekly fortwo months and monthly thereafter. The results of these audits will be reviewed by the CQI committee overseen by theExecutive Director. If threshold of 95%is not achieved, an action plan will be developed to ensure compliance. Date of compliance 04/18/14</p>		

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K010064 SS=F	<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</p> <p>1. Based on observation and interview, the facility failed to ensure 5 of 13 portable fire extinguishers were given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. This deficient practice could affect all residents since the extinguishers were distributed in every smoke compartment which contained resident sleeping rooms, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:30 p.m. to 3:00 p.m. on 03/24/14, the 360 Services inspection tag affixed to the portable fire extinguishers by Room 107, Room 125, Room 139, Room 156 and by the storage room by the Salon did not indicate the date the most</p>	K010064	<p>K064 – Portable Fire Extinguishers It is the intent of the provider to ensure portable fire extinguishers are available in all health care occupancies in accordance with 9.7.4.1 19.3.5.6, NFPA 10 What corrective actions will be accomplished for those found to have been affected by the alleged deficient practice? The fire extinguishers by room 107, 125, 139, and 156 and the salon have been inspected and maintenance performed by 360. The fire extinguisher in the maintenance office was recharged. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All residents have the potential to be affected by the deficient practice. The Maintenance Director will ensure all fire extinguishers are maintained and documentation is available. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur? The Maintenance Director will check fire extinguishers every month. Each fire extinguisher will receive maintenance no more than one year apart. The Maintenance</p>	04/18/2014			

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	<p>recent annual maintenance was performed. Based on interview at the time of the observations, the Maintenance Director stated no other fire extinguisher maintenance documentation was available for review and acknowledged the aforementioned portable fire extinguishers did not have documented annual maintenance within the most recent twelve month period.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 13 portable fire extinguishers had pressure gauge readings in the acceptable range. LSC 4.5.6 requires any fire protection system, building service equipment, feature of protection or safe guard provided for life safety shall be designed, installed and approved in accordance with applicable NFPA standards. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect two staff and visitors in the maintenance office.</p>		<p>Director will complete the monthly preventative maintenance documentation for fire extinguishers. The Executive Director will review preventative maintenance checks monthly. How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? The Maintenance Director/designee with be responsible to complete the Life SafetyReview CQI weekly for four weeks, bi-weekly for two months and monthly thereafter. The results of these audits will be reviewed by the CQI committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Date of compliance 04/18/14</p>				

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:30 p.m. to 3:00 p.m. on 03/24/14, the pressure gauge on the portable fire extinguisher affixed to a hanger on the wall in the maintenance office showed the extinguisher was undercharged. The inspection tag on the portable fire extinguisher listed the most recent annual inspection was in September 2013 and the most recent monthly inspection was March 2014. Based on interview at the time of observation, the Maintenance Director acknowledged the maintenance office portable fire extinguisher pressure gauge indicated the fire extinguisher was undercharged.</p> <p>3.1-19(b)</p>				

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K010069 SS=D	<p>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 and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1999 edition, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect five staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on review of 360 Services "Suppression System Test" documentation dated 11/11/13 during record review with the Maintenance Director from 9:35 a.m. to 11:50 a.m. on 03/24/14, documentation of semiannual hood extinguishing systems inspection six months prior to 11/11/13 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of semiannual hood extinguishing systems inspection six months prior to 11/11/13 was not available for review.</p>	K010069	<p>K069 – Hood Inspection It is the intent of the provider to ensure cooking facilities are protected in accordance with 9.2.3 19.3.2.6 NFPA 96 What corrective actions will be accomplished for those found to have been affected by the alleged deficient practice? The kitchen hood system was inspected by 360 in November 2013 and is scheduled to be inspected in May, 2014. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All residents have the potential to be affected by the deficient practice. The Maintenance Director will ensure the hood system is inspected two times each year by 360 and documentation is available for inspections. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur? The Maintenance Director will ensure that the hood is inspected semi-annually. The hood inspections will be added to the preventative maintenance calendar in May and November. How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance</p>	04/18/2014			

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	3.1-19(b)		program will be put into place? The Maintenance Director/designee with be responsible to complete the Life Safety Review CQI weekly for four weeks, bi-weekly for two months and monthly thereafter. The results of these audits will be reviewed by the CQI committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Date of compliance 04/18/14	

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K010075 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for mobile soiled linen or trash collection receptacles was not exceeded within any 64 square feet area for 1 of 6 corridors. This deficient practice could affect 20 residents, staff or visitor needing to exit the facility from the service corridor.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:30 p.m. to 3:00 p.m. on 03/24/14, eight mobile soiled linen receptacles each contained soiled linen and were unattended and stored next to each other in the service corridor outside the Laundry. The service corridor is marked as a facility exit. Based on interview at 1:45 p.m., the Maintenance Director stated each mobile soiled linen</p>	K010075	<p>K075 – Soiled Linen Receptacles It is the intent of the provider to ensure soiled linen or trash collection receptacles do not exceed 32 gal in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft(20.4 L/sq m). A capacity of 32 gal (121L) is not exceeded within any 64 sq ft (5.9 sq m) area. Mobile soiled linen or trash collection receptacles with capabilities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 What corrective actions will be accomplished for those found to have been affectedby the alleged deficient practice? The eight mobile soiled linen receptacles were moved out of the storage hallway. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All residents in the vicinity</p>	04/18/2014			

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	<p>receptacle was less than 32 gallon capacity, the eight carts together totaled more than than 32 gallons and acknowledged a capacity of greater than 32 gallons was unattended and stored next to each other within a 64 square feet corridor area outside the Laundry.</p> <p>3.1-19(b)</p>		<p>of the service hallway have the potential to be affected by the deficient practice. The Laundry Supervisor will ensure soiled linen is stored in a room protected as a hazardous area when not attended. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur? The laundry staff will be educated on soiled linen storage by 4/18/14. The Laundry Supervisor/designee will ensure laundry is properly stored daily. How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? The Laundry Supervisor/designee will complete the Environmental Safety – Laundry CQI weekly for four weeks, bi-weekly for two months, and monthly thereafter. The results of these audits will be reviewed by the CQI committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Date of compliance 04/18/14</p>		

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K010130 SS=C	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 62 of 62 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Smoke Detector Maintenance Log for 2013 and 2014" documentation with the Maintenance Director during record review from 9:35 a.m. to 11:50 a.m. on 03/24/14, documentation of battery operated smoke detector cleaning within the most recent twelve month period was not available for review. The aforementioned maintenance log documented testing for the twelve month period of April 2013 through March 2014 but did not document any periodic cleaning. Based on observations with the Maintenance Director during a tour of the facility from 12:30 p.m. to 3:00 p.m. on 03/24/14, battery operated smoke</p>	K010130	<p>K130 – PM for smoke detectors It is the intent of the provider to maintain a preventative maintenance program for battery operated smoke detectors installed in sleeping rooms. What corrective actions will be accomplished for those found to have been affected y the alleged deficient practice? All smoke detectors in residents' rooms were tested and cleaned in April,2014. The testing and cleaning documentationis present. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All residents have the potential to be affected by the deficient practice. The Maintenance Director will complete testing and cleaning documentation monthly. The Executive Director will review preventative maintenance monthly to ensure tasks are completed. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur? The Maintenance Director will complete documentation of testing and cleaning on the Battery Operated Smoke Detector Maintenance Log for 2014 monthly. The Executive Director</p>	04/18/2014	

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	<p>detectors are installed in each of 62 resident sleeping rooms. Manufacturer's specifications affixed to each Kidde Model i9010 smoke detector stated to clean the detector annually.</p> <p>Manufacturer's specifications affixed to each First Alert Model SA340 smoke detector installed in resident rooms 103, 114, 120, 122, 134, 135 and 153 stated to clean the detector monthly. Based on interview at the time of record review and of the observations, the Maintenance Director stated each battery operated smoke detector is cleaned with compressed air at the time of monthly testing but acknowledged cleaning documentation for the most recent twelve month period was not available for review.</p> <p>3.1-19(a)</p>		<p>will review the Preventative Maintenance Documentation monthly. How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? The Maintenance Director will complete the Life Safety Review CQI weekly for fourweeks, bi-weekly for two months, and monthly thereafter. The results of these audits will be reviewedby the CQI committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Date of compliance 04/18/14</p>		

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K010144 SS=C	<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>1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 1 of 12 months 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. NFPA 99,</p>	K010144	<p>K144 Generator testing It is the intent of the provider to have generators inspected weekly under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1 What corrective actions will be accomplished for those found to have been affected by the alleged deficient practice? The Maintenance Director and assistant will be educated on the weekly and monthly generator testing and the preventative maintenance schedule by 4/18/14. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken All residents have the potential to be affected by the deficient practice. The Maintenance Director will complete the weekly and monthly exercise and load test log. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur? The Maintenance Director will complete the weekly and monthly exercise and loadtest log. The Executive Director will review the documentation monthly. How the corrective actions will be monitored to ensure the deficient</p>	04/18/2014			

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	<p>3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator-Weekly Exercise/Monthly Load Test Log" documentation with the Maintenance Director during record review from 9:35 a.m. to 11:50 a.m. on 03/24/14, documentation for the 03/07/14 load test for March 2014 did not state minimum exhaust gas temperature, operating temperature conditions recommended by the manufacturer or under load at not less than 30 percent of the EPS nameplate rating. The "load kW" for the load test was blank on the aforementioned monthly load test. Based on interview at the time of record review, the Maintenance Director acknowledged documentation for the March 2014 monthly load test was incomplete.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of</p>		<p>practice will not recur and what quality assurance program will be put into place? The Maintenance Director will complete the Life Safety Review CQI weekly for fourweeks, bi-weekly for two months, and monthly thereafter. The results of these audits will be reviewedby the CQI committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. What date of compliance? 04/18/14</p>				

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	<p>the starting batteries for the emergency generator was maintained for 4 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator-Weekly Exercise/Monthly Load Test Log" documentation with the Maintenance Director during record review from 9:35 a.m. to 11:50 a.m. on 03/24/14, documentation of weekly inspections of the starting batteries for the emergency generator for the the first and fourth week of January and February</p>						

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	<p>2014 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of weekly inspections of the starting batteries for the emergency generator for the the first and fourth week of January and February 2014 was not available for review.</p> <p>3.1-19(b)</p>			
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