

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2013
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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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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: 05/20/13</p> <p>Facility Number: 002667 Provider Number: 155678 AIM Number: 200300090</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist; Robert Sutton Life Safety Code Specialist Trainee</p> <p>At this Life Safety Code survey, Waterford Place Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. The original building (1)consisting of 100, 200, 300, 400 and 600 halls was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire</p>	K010000	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the accuracy or validity of the findings as alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law.Please accept this Plan of Correction as Waterford Place Health Campus' Credible Allegation of Compliance. Waterford Place Health Campus respectfully requests desk review of it's Plan of Correction for paper compliance.</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>alarm system with hard wired smoke detection in the corridors, in resident sleeping rooms and in spaces open to the corridors. The facility has a capacity of 106 and had a census of 86 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered except for the Soiled Utility room on 400 hall. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/31/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010018 SS=E	<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 observations and interview, the facility failed to ensure 2 of 2 double leaf corridor doors could latch into their door frames. This deficient practice affects 10 residents on TCS east hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 05/20/13 during the tour between 12:15 p.m. to 3:00 p.m., the double leaf corridor doors on TCS Dining room required one door to be latched manually into the door frame before the second door would latch into the first door and secure them both tightly into the door frame. Based on interview on 05/20/13 concurrent with the observations, it was acknowledged by the</p>	K010018	<p>1. No residents were affected.2. No residents were affected.3. The identified doors have been fitted with latching devices that allow for the doors to latch securely within the door frame. The Director of Plant Operations (DPO) or his designee will inspect for, as part of the monthly door security check, that the identified doors operate appropriately and latch securely.4. The DPO will bring the results of these inspections to the monthly QAA Committee meeting for review for the next three months and then quarterly.5. June 19, 2013.</p>	06/19/2013			

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	<p>Maintenance Supervisor, each of the aforementioned corridor doors could not latch independently into the door frame.</p> <p>3.1-19(b)</p>			

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K010046 SS=E	<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 and interview, the facility failed to ensure 1 of 11 battery operated lights were maintained to provide emergency powered illumination. LSC 7-9.2 requires emergency lighting shall be provided for not less than 1 1/2 hours, arranged to provide not less than an average of 1 foot candle and not less than 0.1 foot candles, measured along the path of egress at floor level. This deficient practice could affect 8 residents in the adjacent Dining room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 05/20/13 at 1:39 p.m. with the Maintenance Supervisor the battery powered emergency light located in the Mechanical room on Service hall, east of the Dining room did not illuminate when tested. Based on interview on 05/20/13 at 1:41 p.m. with the Maintenance Supervisor it was confirmed the battery powered emergency light did not illuminate when tested.</p> <p>3.1-19(b)</p>	K010046	<p>1. No residents were affected.2. No residents were affected.3. The identified emergency light has been repaired. The Director of Plant Operations (DPO) or his designee will inspect for, as part of the monthly emergency lighting systems check, that all emergency lighting is operating appropriately.4. The DPO will bring the results of these inspections to the monthly QAA Committee meeting for review for the next three months and then quarterly.5. June 19, 2013.</p>	06/19/2013			

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K010048 SS=F	<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 "ABC" and "K" 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 pan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all residents in the facility 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 05/20/13 at 3:45 p.m. with the Maintenance Supervisor, the fire disaster plan did not include the use and location of the K-class extinguisher located in the kitchen in relationship with</p>	K010048	<p>1. No residents were affected.2. No residents were affected.3. The facility's written fire disaster plan was immediately revised to include the use and location of the K-class extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguisher system and the ABC fire extinguishers throughout the facility as an all purpose extinguisher. The Director of Plant Operations (DPO) or his designee will inspect for, as part of the monthly fire extinguisher check, that the K-class and ABC-class fire extinguishers are identified and located in their appropriate location(s).4. The DPO will bring the results of these inspections to the monthly QAA Committee meeting for review for the next three months and then quarterly.5. June 19, 2013.</p>	06/19/2013			

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	<p>the use of the kitchen overhead extinguishing system and the ABC fire extinguishers throughout the facility as an all purpose extinguisher. Based on an interview on 05/20/13 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 or the ABC fire extinguishers.</p> <p>3.1-19(b)</p>			

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 16 rooms on 400 west was provided with an automatic sprinkler head to ensure sprinkler coverage in all portions of the building. This deficient practice could affect 22 residents as well as visitors or staff.</p> <p>Findings include:</p> <p>Based on observation on 05/20/13 at 1:20 p.m. with the Maintenance Supervisor, the Soiled utility room on 400 hall west was not provided with sprinkler protection. Based on interview on 05/20/13 concurrent with the observation, it was acknowledge by the Maintenance Supervisor the Soiled utility room was not equipped with sprinkler protection in order to provide complete sprinkler</p>	K010056	<p>1. No residents were affected.2. No residents were affected.3. An automatic sprinkler head was installed in the soiled utility closet located on the 400 hall. The Director of Plant Operations (DPO) or his designee will inspect for, as part of the monthly emergency systems check, that all areas of the facility are equipped with sprinkler protection in order to provide complete sprinkler coverage to all areas of the facility.4. The DPO will bring the results of these inspections to the monthly QAA Committee meeting for review for the next three months and then quarterly.5. June 19, 2013.</p>	06/19/2013			

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	coverage to all areas of the facility. 3.1-19(b) 3.1-19(ff)			

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K010061 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on record review, observation and interview; the facility failed to electronically supervise 1 of 2 Post Indicator Valves (PIV). LSC Section 9.7.2.1 requires supervisory attachments to be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code and a distinctive supervisory signal to be provided to indicate a condition which would impair the satisfactory operation of the sprinkler system. This deficient practice could affect all residents in the facility as well as staff and visitors, if the water to the sprinkler system was shut off and not detected due to lack of supervision.</p> <p>Findings include:</p> <p>Based on review of quarterly sprinkler inspection reports documentation with the Maintenance Supervisor during record review at 3:33 p.m. on 05/20/13, the PIV located outside of 600 hall west lacked electronic supervision since Koorsen had performed quarterly sprinkler inspections and made no mention of electronic supervision. Based on observation on 05/20/13 at 4:00 p.m. with the</p>	K010061	<p>1. No residents were affected.2. No residents were affected.3. Electronic supervision was installed on the Post Indicator Valve (PIV) located outside the 600 hall. The Director of Plant Operations (DPO) or his designee will inspect for, as part of the monthly emergency systems check, that all facility PIVs have electronic supervision that is operational.4. The DPO will bring the results of these inspections to the monthly QAA Committee meeting for review for the next three months and then quarterly.5. June 19, 2013.</p>	06/19/2013

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	<p>Maintenance Supervisor, the PIV was secured with a lock, but lacked electronic supervision. Based on interview at the time of record review and observation, the Maintenance Supervisor acknowledged the PIV was not electronically supervised.</p> <p>3.1-19(b)</p>			

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K010062 SS=D	<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 ensure 1 of 2 sprinkler heads observed in the Beauty shop was free of paint and 1 of 4 sprinkler heads in the Laundry room was not damaged. 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 35 residents on 500 hall and 8 residents in the Dining room adjacent to the Laundry room as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 05/20/13 at 2:30 p.m. with the Maintenance Supervisor, one sprinkler head located in the Beauty shop on 500 hall was covered with white paint and one sprinkler head located in the laundry room adjacent to the Dining room had a bent deflector. Based on interview on 05/20/13 at 2:31 p.m. with the Maintenance Supervisor, it was confirmed the sprinkler head located in the Beauty shop was covered in paint and one sprinkler head in the Laundry room had a</p>	K010062	<p>1. No residents were affected.2. No residents were affected.3. Both sprinkler heads identified were replaced. The Director of Plant Operations (DPO) or his designee will inspect for, as part of the monthly emergency systems check, that all areas of the facility are equipped with sprinkler heads that are not painted, corroded, damaged, loaded, or in the improper orientation.4. The DPO will bring the results of these inspections to the monthly QAA Committee meeting for review for the next three months and then quarterly.5. June 19, 2013.</p>	06/19/2013			

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K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 multiplug adapters was not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 35 residents on 500 hall as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 05/20/13 at 2:33 p.m. with the Maintenance Supervisor, there was one, three prong multiplug adapter connected to a surge protector in the Beauty shop on 500 hall. Based on interview on 05/20/13 concurrent with the observation with the Maintenance Supervisor it was acknowledged it is the policy of the facility to not use multiplug adapters, however, the aforementioned room did use a three prong multiplug as a substitute for fixed wiring.</p> <p>3.1-19(b)</p>	K010147	<p>1. No residents were affected.2. No residents were affected.3. The three-prong multiplug adapter was removed. The Director of Plant Operations (DPO) or his designee will inspect for, as part of the weekly safety inspection check, that all areas of the facility are free of multiplug adapters being used as a substitute for fixed wiring, unless specifically permitted.4. The DPO will bring the results of these inspections to the monthly QAA Committee meeting for review for the next three months and then quarterly.5. June 19, 2013.</p>	06/19/2013			

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K020000	<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: 05/20/13</p> <p>Facility Number: 002667 Provider Number: 155678 AIM Number: 200300090</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist; Robert Sutton Life Safety Code Specialist Trainee</p> <p>At this Life Safety Code survey, Waterford Place Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. Rooms 201 to 208 on 200 hall of the Legacy building (2) which is completely separate from the original building was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and was</p>	K020000	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the accuracy or validity of the findings as alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law. Please accept this Plan of Correction as Waterford Place Health Campus' Credible Allegation of Compliance. Waterford Place Health Campus respectfully requests desk review of it's Plan of Correction for paper compliance.</p>	

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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901			
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	<p>fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, in resident sleeping rooms and in spaces open to the corridors. The facility has a capacity of 103 and had a census of 83 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered except for the Soiled Utility room on 400 hall. All areas providing facility services were 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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K020018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observations and interview, the facility failed to ensure 1 of 1 double leaf corridor doors could latch into their door frame. This deficient practice affects 28 residents in the Legacy building as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 05/20/13 at 2:30 p.m., the double leaf corridor doors in the Legacy Club required one door to be latched manually into the door frame before the second door would latch into the first door and secure them both tightly into the door frame. Based on interview on 05/20/13 concurrent with the observations, it was acknowledged by the Maintenance Supervisor, each of the aforementioned corridor doors could not latch independently into the door frame.</p> <p>3.1-19(b)</p>	K020018	<p>1. No residents were affected.2. No residents were affected.3. The identified doors have been fitted with latching devices that allow for the doors to latch securely within the door frame. The Director of Plant Operations (DPO) or his designee will inspect for, as part of the monthly door security check, that the identified doors operate appropriately and latch securely.4. The DPO will bring the results of these inspections to the monthly QAA Committee meeting for review for the next three months and then quarterly.5. June 19, 2013.</p>	06/19/2013	

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K020048 SS=F	<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. 18.7.1.1 Based on record review and interview, the facility failed to include the use of the "ABC" and "K" 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 pan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all residents in the facility 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 05/20/13 at 3:45 p.m. with the Maintenance Supervisor, the fire disaster plan did not include the use and location of the K-class extinguisher located in the kitchen in relationship with</p>	K020048	<p>1. No residents were affected.2. No residents were affected.3. The facility's written fire disaster plan was immediately revised to include the use and location of the K-class extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguisher system and the ABC fire extinguishers throughout the facility as an all purpose extinguisher. The Director of Plant Operations (DPO) or his designee will inspect for, as part of the monthly fire extinguisher check, that the K-class and ABC-class fire extinguishers are identified and located in their appropriate location(s).4. The DPO will bring the results of these inspections to the monthly QAA Committee meeting for review for the next three months and then quarterly.5. June 19, 2013.</p>	06/19/2013			

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	<p>the use of the kitchen overhead extinguishing system and the ABC fire extinguishers throughout the facility as an all purpose extinguisher. Based on an interview on 05/20/13 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 or the ABC fire extinguishers.</p> <p>3.1-19(b)</p>			

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K020056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 sprinkler heads on 200 hall were installed in accordance with NFPA 13 in areas where there were no obstructions which would influence the the range of protection on 200 hall. NFPA 13, 5-5.5.1, states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-5.5.2 and 5-5.5.3 or additional sprinklers shall be provided. This deficient practice could affect 20 residents in the Legacy as well as visitors or staff.</p> <p>Findings include:</p> <p>Based on observation on 05/20/13 at 1:20 p.m. with the Maintenance Supervisor, the sprinkler head next to room # 209 was</p>	K020056	<p>1. No residents were affected.2. No residents were affected.3. An automatic sprinkler head was installed in the soiled utility closet located on the 400 hall. The Director of Plant Operations (DPO) or his designee will inspect for, as part of the monthly emergency systems check, that all areas of the facility are equipped with sprinkler protection in order to provide complete sprinkler coverage to all areas of the facility.4. The DPO will bring the results of these inspections to the monthly QAA Committee meeting for review for the next three months and then quarterly.5. June 19, 2013.</p>	06/19/2013

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	<p>located on the ceiling directly adjacent to a fluorescent light which would subsequently block the range of sprinkler coverage.</p> <p>Based on interview on 05/20/13 concurrent with the observation, it was acknowledge by the Maintenance Supervisor the sprinkler head was blocked by the ceiling light and could affect its sprinkler coverage.</p> <p>3.1-19(b) 3.1-19(ff)</p>			

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K020068 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 ventless gas fireplaces was connected to a chimney or vent and installed in accordance with Exception No. 2 to LSC Section 19.5.2.2. Exception No. 2 states the fireplace shall be equipped with a fireplace enclosure guaranteed against breakage up to a temperature of 650 degrees Fahrenheit and constructed of heat tempered glass or other approved material. In addition, LSC 9.2.2 states ventilating or heat producing equipment shall be in accordance with NFPA 54, National Fuel Gas Code, 1999 Edition. NFPA 54 defines a decorative appliance for installation in a vented fireplace as a self contained, freestanding, fuel-gas burning appliance designed for installation only in a vented fireplace and whose primary function lies in the aesthetic effect of the flame. Section 6.6.2 states a decorative appliance for installation in a vented fireplace shall be installed only in a vented fireplace having a working chimney flue and constructed of noncombustible materials. This deficient practice could affect 5 residents as well as staff and visitors in the Legacy Main Entrance reception area.</p>	K020068	<p>1. No residents were affected.2. No residents were affected.3. The gas log has been disconnected and pipeline capped. The Director of Plant Operations (DPO) or his designee will inspect for, as part of the monthly emergency systems check, that gas log identified is properly disconnected.4. The DPO will bring the results of these inspections to the monthly QAA Committee meeting for review for the next three months and then quarterly.5. June 19, 2013.</p>	06/19/2013			

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	<p>Findings include:</p> <p>Based on observation on 05/20/13 at 3:40 p.m. with the Maintenance Supervisor, the Legacy Main Entrance reception area has a self contained, natural gas fired fireplace which was not connected to a chimney or vent. The front opening of the fireplace was covered with glass for viewing the flames. The gas fueled fireplace was not turned on at this time, however, based on interview concurrent with the observation, the Maintenance Supervisor acknowledged the gas fueled fireplace is used during the Winter months and was not connected to a chimney or vent.</p> <p>3.1-19(b)</p>				