

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155294	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/02/2015
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NAME OF PROVIDER OR SUPPLIER FORUM AT THE CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240
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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: 01/02/15</p> <p>Facility Number: 000191 Provider Number: 155294 AIM Number: NA</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Forum at the Crossing 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 fully sprinklered except for the exterior fabric canopy at the Main Entrance. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The</p>	K010000		

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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K010018 SS=E	<p>facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 74 and had a census of 61 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered except for the exterior fabric canopy at the Main Entrance. All areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 01/08/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p>			

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	<p>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 3 of over 75 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 15 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:55 a.m. to 1:30 p.m. on 01/02/15, the corridor door to the Memory Care Director's Office, Memory Care Activities Room and to the Maintenance Office were each propped in the fully open position with an affixed kick down door stop. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned corridor doors failed to resist the passage of smoke and provided an impediment to closing and latching.</p> <p>3.1-19(b)</p>	K010018	<p>Submission of this Plan of Correction is a requirement established with licensure by the State of Indiana. This submission does not constitute an admission of the statements of findings by the Indiana State Department of Health. Rather, it serves as a compliance vehicle under licensure mandates. K 022 In response to cited findings, the following actions will be taken: NFPA 101 LIFESAFETY CODE STANDARD LSC 19.3.6.3 No impediment to the closing of doors. A) Manual doorstops were removed immediately following the survey. B) All residents of the Memory Care Unit and visiting residents from the SNF unit are potentially affected by doors allowing smoke and/or flames to pass between designated spaces when emergencies occur. C) The Maintenance Director and/or his designee will perform monthly inspections with related documentation to monitor proper closure of all fire-rated doors separating spaces used by residents, visitors and staff members. Any doors found to be impeded from proper closing will have adjustments or repairs as indicated. Doors impeded for utility purposes may have electromagnetic releases applied</p>	01/16/2015

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K010025 SS=E	<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>1. Based on observation and interview, the facility failed to ensure ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 32 residents, staff and visitors in the 500 Hall.</p>			K010025	<p>for use with the fire alarm system. These devices will be employed to allow door closures whenever fire alarms are activated. D) The HFA will include observations of fire/smoke barrier doors during environmental rounds no less than once monthly. He will ensure the Maintenance Director keeps accurate and up-to-date reports of inspections. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of Compliance with proposed actions: January 16, 2015</p> <p>K 025 <i>In response to cited findings, the following actions will be taken:</i> NFPA 101 LIFESAFETY CODE STANDARD LSC 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Smoke barriers in ceilings shall be maintained intact so as to prevent passage of smoke between compartments. A) These openings will be</p>		02/01/2015

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Assistant during a tour of the facility from 10:55 a.m. to 1:30 p.m. on 01/02/15, three penetrations of the ceiling smoke barrier in the 500 Hall Environmental Services Room by Room 509 were sealed with expandable foam which is not an approved material for maintaining the smoke resistance of a smoke barrier. Based on interview at the time of observation, the Maintenance Assistant stated documentation of the fire resistance rating of the expandable foam was not available for review and acknowledged the aforementioned openings in the ceiling smoke barrier in the 500 Hall Environmental Services Room by Room 509 did not provide at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure openings through 1 of 12 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. This deficient practice could affect 30 residents, staff and visitors in the 400 Hall.</p> <p>Findings include:</p>		<p>properly filled with approved materials to preclude passage of smoke:</p> <ul style="list-style-type: none"> ·Three (3) penetrations in the 500 hall environmental services room by #509. ·1/2" space surrounding two (2) pipes by #400 <p>B) All residents of areas where smoke barriers are not fully intact have the potential to be affected by incomplete barriers. C) The Maintenance Director and/or his designee will conduct a full inspection of the physical plant to include all penetrations of smoke barriers. All openings without sufficient closure will be corrected with appropriate materials to preclude smoke penetration. Visual inspections of smoke barriers and proper sealing will be conducted when monthly fire extinguisher checks are performed. Any improper penetrations will be corrected within 48 hours of identification. D) The HFA will include observations of smoke barrier maintenance on environmental rounds for the next sixty (60) days. Following that he will review records on a monthly basis. He will ensure the Maintenance Director addresses any related findings. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of compliance with proposed actions: February 1, 2015</p>				

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K010029 SS=E	<p>Based on observation with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 10:55 a.m. to 1:30 p.m. on 01/02/15, the one half inch annular space surrounding two six inch in diameter pipes which penetrated the smoke barrier wall above the suspended ceiling at the cross corridor door set by Room 400 were not firestopped. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned openings in the smoke barrier wall above the suspended ceiling failed to maintain the smoke resistance of the smoke barrier.</p> <p>3.1-19(b)</p> <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</p>			

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	<p>inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 11 hazardous areas were separated from other spaces by smoke resistant partitions and doors. This deficient practice could affect 22 staff and visitors in the vicinity of the 400 Hall Mechanical Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Assistant during a tour of the facility from 10:55 a.m. to 1:30 p.m. on 01/02/15, the 400 Hall Mechanical Room contained a natural gas fired furnace. The one half inch annular space surrounding three of ten one half inch in diameter pipes which penetrated the ceiling of the 400 Hall Mechanical Room were not smoke resistant and failed to separate this hazardous area from other spaces with smoke resistant partitions. Based on interview at the time of observation, the Maintenance Assistant acknowledged the aforementioned hazardous area was not separated from other spaces with smoke resistant partitions.</p> <p>3.1-19(b)</p>	K010029	<p>K 029 In response to cited findings, the following actions will be taken: NFPA 101 LIFESAFETY CODE STANDARD LSC 19.3.2.1 One-hour fire rated construction protects hazardous areas.</p> <p>1. These openings will be properly filled with approved materials to preclude passage of smoke:</p> <ul style="list-style-type: none"> - Three (3) one-half inch diameter pipes with 1/2" of space penetrating a ceiling in the 400 hall mechanical room. B) All residents of areas where smoke barriers are not fully intact have the potential to be affected by incomplete barriers. C) The Maintenance Director and/or his designee will conduct a full inspection of the physical plant to include all penetrations of smoke barriers. All openings without sufficient closure will be corrected with appropriate materials to preclude smoke penetration. Visual inspections of smoke barriers and proper sealing will be conducted when monthly fire extinguisher checks are performed. Any improper penetrations will be corrected within 48 hours of identification. D) The HFA will include observations of smoke barrier maintenance on his weekly environmental rounds for the next sixty (60) days. Following that he will review records on a monthly 	02/01/2015

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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>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 15 residents, staff and visitors if needing to exit the facility from the Memory Care BTR Dining Room.</p>	K010038	<p>basis. He will ensure the Maintenance Director addresses any related findings. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of compliance with proposed actions: February 1, 2015</p> <p>K 038 <i>In response to cited findings, the following actions will be taken:</i> NFPA 101 LIFESAFETY CODE STANDARD LSC 7.1. 19.2.1, 7.2.1.6.1 Exit access shall be readily accessible at all times. A) Hardware provided to lock the garden gate in this courtyard was removed so individuals can pass freely outside of the area to a public way. B) All residents using the Memory Care BTR dining room and/or in urgent need of exiting the Memory Care BTR unit could potentially be affected by assuming the garden gate was unimpeded and finding it to be locked. C) The Maintenance Director will keep a floor plan showing exits and non-exit exterior doors with monthly fire protection monitoring. He or his designee will observe exterior barriers on a monthly basis when fire extinguishers are checked. If exits are found to operate improperly, they will be adjusted</p>	02/01/2015

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K010050 SS=F	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:55 a.m. to 1:30 p.m. on 01/02/15, the exit door in the Memory Care BTR Dining Room is marked as a facility exit with an exit sign and leads to a fenced courtyard. The courtyard exit to the public way is locked from the other side and could not be unlocked from the courtyard. Based on interview at the time of observation, the Maintenance Director acknowledged the courtyard exit from the aforementioned dining room exit was locked and could not be opened from the courtyard.</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</p>				<p>by facility personnel and/or outside contractors as indicated.</p> <p>D) The HFA will include observations of proper exit functionality on environmental rounds no less than monthly. He will ensure the Maintenance Director keeps exterior impediments in operational order. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of compliance with proposed actions: February 1, 2015</p>		

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	<p>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 first and third 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 "Fire Drill Report Form" and "Fire Drill and False Alarm Log" with the Maintenance Director during record review from 9:30 a.m. to 10:55 a.m. on 01/02/15, the following was noted:</p> <p>a. documentation for the first shift fire drill conducted on 02/28/14 stated the drill was conducted on the first shift but did not include the time of day the drill was conducted.</p> <p>b. documentation of a fire drill conducted on the third shift in the first quarter of 2014 was not available for review.</p> <p>Based on interview at the time of review, the Maintenance Director stated no other fire drill documentation was available for review and acknowledged documentation for the first shift fire drill conducted on 02/28/14 did not include the time of day the fire drill was conducted and documentation of a fire drill conducted on the third shift in the first quarter of</p>	K010050	<p>K 050 In response to cited findings, the following actions will be taken: NFPA 101 LIFESAFETY CODE STANDARD LSC 9.7.1.2 Fire drills are held at unexpected times under varying conditions. A) Documentation of fire drills contains times, dates and other salient details. This finding relates to incomplete document recorded about 11 months prior. Records have been comprehensive to include all required elements since then. B) All residents of the community have the potential to be affected if/when staff members are not familiar with drills designed to facilitate emergency responses related to fires. C) The Maintenance Director keeps records of fire/emergency drills which indicate date/time/shift and other pertinent information. Reminders are documented via TELS and/or ancillary systems. The Maintenance Director and/or his designee will continue to perform monthly drills and provide documentation to ensure comprehensive records are in order. D) The HFA will include observations of both fire drills and summary forms with environmental rounds no less than once monthly. He will ensure the Maintenance Director keeps accurate and up-to-date reports of inspections. Assigned</p>	02/01/2015	

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	<p>2014 was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first, second and third shift for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report Form" and "Fire Drill and False Alarm Log" with the Maintenance Director during record review from 9:30 a.m. to 10:55 a.m. on 01/02/15, the following was noted:</p> <p>a. first shift (6:00 a.m. to 2:30 p.m.) fire drills conducted on 04/25/14, 07/08/14 and 10/22/14 were conducted at, respectively, 2:00 p.m., 1:35 p.m. and 1:50 p.m.</p> <p>b. second shift (2:30 p.m. to 11:00 p.m.) fire drills conducted on 03/26/14, 5/30/14, 08/21/14 and 11/28/14 were conducted at, respectively, 3:05 p.m., 4:00 p.m., 2:42 p.m. and 2:45 p.m.</p> <p>c. third shift (11:00 p.m. to 6:00 a.m.) fire drills conducted on 06/30/14, 9/30/14 and 12/30/14 were conducted at, respectively, 5:00 a.m., 5:00 a.m. and 6:00 a.m.</p>		<p>staff members who fail to maintain compliance will be reprimanded. E) Date of compliance with proposed actions: February 1, 2015</p>	

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K010051 SS=E	<p>Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned fire drills were not conducted at unexpected times under varying conditions for each shift.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 2 of 8 exit door electromagnetic locks connected to the fire alarm system remained unlocked while the fire alarm was activated. LSC</p>	K010051	K 051 <i>In response to cited findings, the following actions will be taken:</i> NFPA 101 LIFE SAFETY CODE STANDARD LSC 19.3.4.9.6. Actuation of locking systems when fire alarm systems	02/01/2015

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	<p>9.6.1.3 says the provisions of 9.6 cover the basic functions of a complete fire alarm system. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 3-9.7.1 states any device or system intended to actuate the locking or unlocking of exits shall be connected to the fire alarm system serving the protected premises. NFPA 72, 3-9.7.2 states all exits connected in accordance with 3-9.7.1 shall unlock upon receipt of any fire alarm signal by means of the fire alarm system serving the protected premises.</p> <p>Exception: Where otherwise required or permitted by the authority having jurisdiction.</p> <p>This deficient practice could affect 75 residents, staff and visitors if needing to exit the facility from the 400 Hall and the 600 Hall.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 10:55 a.m. to 1:30 p.m. on 01/02/15, the electromagnetic lock on the facility exit to the exterior from the 600 Hall near Room 630 and the electromagnetic lock on the facility exit to the exterior from the 400 Hall near</p>		<p>are engaged. A) Electromagnetic locks on the 400 and 600 halls, near rooms #428 and #620, respectively were linked to disengage when the fire alarm is activated by an outside contractor.</p> <p>B) All residents of areas where designated exits are not released upon activation of fire alarms have the potential to be affected by this alleged condition. C) The Maintenance Director and/or his designee will conduct a full inspection of the physical plant to include release of electromagnetic locks protecting exits. Any lock found not to release during activation of alarms will be revised to ensure proper functionality. Any non-compliant exits will be corrected within 48 hours of identification. Following the 100% audit (and related repairs) the Maintenance Director or his designee will inspect random exits during monthly fire drills or more frequently if indicated. D) The HFA will include observations of electromagnetic door releases on his fire alarm compliance inspections for the next sixty (60) days. Following that he will review records on a monthly basis. He will ensure the Maintenance Director addresses any related findings. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of compliance with proposed actions: February 1, 2015</p>	

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K010052 SS=B	<p>Room 428 each did not remain unlocked when the fire alarm was activated at 12:43 p.m., 12:51 p.m. and 12:55 p.m. After activation of the fire alarm system at each of three aforementioned times and subsequent silencing of the system, all electromagnetic locks in the building at facility exits to the exterior of the building remained unlocked except for the aforementioned two facility exits. Based on interview at the time of the observations, the Maintenance Director acknowledged the electromagnetic locks on the aforementioned two facility exits did not remain unlocked while the fire alarm system was activated.</p> <p>3.1-19(b)</p> <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 Based on observation and interview, the facility failed to maintain 1 of over 25 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in</p>	K010052	K 052 In response to cited findings, the following actions will be taken: NFPA 101 LIFESAFETY CODE STANDARD LSC 19.6.1.4 Smoke detectors	01/16/2015

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K010056	<p>spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect 15 residents, staff and visitors in the vicinity of Room 628.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:55 a.m. to 1:30 p.m. on 01/02/15, the smoke detector mounted on the ceiling in the corridor outside Room 628 was located two feet from an air supply vent. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned smoke detector was located on the ceiling less than three feet from an air supply vent.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		<p>near air handling systems. A) The cited smoke detector was moved immediately following the survey to greater than 36" from the noted air supply vent. B) All residents of the Memory Care and SNF units are potentially affected by malfunctions of fire alarm sensor. C) The Maintenance Director and/or his designee will perform monthly inspections with related documentation to monitor proper placement of smoke detector sensors vis-à-vis air handling vents. Any found to be improperly located will be moved as indicated for compliance. D) The HFA will include observations of smoke detector placements with environmental rounds no less than once monthly. He will ensure the Maintenance Director keeps accurate and up-to-date reports of inspections. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of Compliance with proposed actions: January 16, 2015</p>				

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SS=E	<p>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 provide sprinkler coverage for 1 of 1 combustible exterior canopies wider than 4 feet. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect 40 residents, staff and visitors if needing to exit the facility at the main entrance.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:55 a.m. to 1:30 p.m. on 01/02/15, the exterior canopy attached to the building at the main entrance extended fifteen feet from the building, was of fabric construction and was not</p>	K010056	<p>K 056 <i>In response to cited findings, the following actions will be taken:</i> NFPA 101 LIFESAFETY CODE STANDARD LSC 19.3.5 Water-based fire protection system. A) The noted canopy connects to a portion of the building with fully-sprinkled equipment. It has been in place for about 25 years. A fire-protection contractor was contacted immediately following the survey to secure engineering inspections and pricing to extend fire suppression systems to the canopy. B) All residents of the Memory Care and SNF units are potentially affected by this alleged deficiency. C) Upon final approval by ownership engineers and consultants, the water-based fire suppression system will be enlarged to include the fabric canopy. Quotes will be secured to accomplish necessary improvements by February 1,</p>	02/01/2015

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K010070 SS=E	<p>provided with automatic sprinklers. Based on interview at the time of observation, the Maintenance Director stated documentation was not available for review demonstrating the fabric canopy was noncombustible and acknowledged the aforementioned canopy extended more than four feet from the building, was of combustible construction and was not provided with automatic sprinklers.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on observation and interview, the facility failed to ensure portable space heaters were not used in health care occupancies. This deficient practice</p>	K010070	<p>2015. Contracted work will be accomplished within 30 days thereafter, weather-permitting. It must be performed when weather allows plumbing lines to be opened and revised on the exterior of the physical plant. The Maintenance Director and/or his designee will ensure quarterly inspections monitor for complete functionality of the fire suppression system. Any portion found to be faulty will be scheduled for repairs as quickly as possible via contractors. D) The HFA will include observations of sprinkler system maintenance compliance by the Maintenance Director with his environmental rounds. He will ensure the Maintenance Director keeps accurate and up-to-date records of inspections. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of Compliance with proposed actions: February 1, 2015</p> <p>K 070 <i>In response to cited findings, the following actions will be taken:</i> NFPA 101 LIFE SAFETY CODE STANDARD LSC 19.7.8 Portable space heaters.</p>	01/16/2015			

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K010074 SS=B	<p>could affect 15 residents, staff and visitors in the vicinity of Room 619.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:55 a.m. to 1:30 p.m. on 01/02/15, an electric space heater inside a portable decorative fireplace was observed in operation in resident sleeping Room 619. Based on interview at the time of observation, the Maintenance Director acknowledged a portable space heater was in use in resident sleeping Room 619.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics</p>		<p>A) The space heater was removed immediately during the survey. B) All residents of the Memory Care Unit and visiting residents from the SNF unit are potentially affected by space heaters being utilized in the community. C) The Maintenance Director and/or his designee will perform monthly inspections with related documentation to monitor prohibition of electric space heaters. Any portable heaters found will be removed from the premises as indicated. Residents/family members who bring such devices onto the property will be advised of prohibitions against them. Changes to the physical plant may be performed to ensure sufficient heat levels are maintained for residents. D) The HFA will include observations for use of portable space heaters during environmental rounds no less than once monthly. He will ensure the Maintenance Director continues to enforce prohibition of space heaters. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of Compliance with proposed actions: January 16, 2015</p>		

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	<p>and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on record review, observation and interview; the facility failed to ensure window curtains in 1 of 6 smoke compartments were flame resistant. This deficient practice could affect four residents, staff and visitors in the vicinity of the 500 Hall shower room.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:30 a.m. to 10:55 a.m. on 01/02/15, window curtain flame resistant documentation was not available for review. Based on interview at the time of record review, the Maintenance Director stated window curtains in the facility had not been treated with a flame retardant material and acknowledged window curtain flame</p>	K010074	<p>K 074 In response to cited findings, the following actions will be taken: NFPA 101 LIFE SAFETY CODE STANDARD LSC 19.7.5.1 Standards for shower curtains. A) The curtain was removed during the survey. B) All residents of the Memory Care and SNF Units could potentially be affected by fabrics with unknown fire-ratings being utilized in the community. C) The Maintenance Director and/or his designee will perform monthly inspections with related documentation to monitor placement/addition of any hanging fabrics utilized in licensed portions of the community. Any fabrics found without fire rating labels and/or insufficient labels will be removed from the premises as indicated. Residents/family members who bring such items onto the</p>	01/16/2015

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K010147 SS=E	<p>resistant documentation was not available for review. Based on observation with the Maintenance Assistant during a tour of the facility from 10:55 a.m. to 1:30 p.m. on 01/02/15, window curtains installed in the 500 Hall shower room had no affixed documentation stating the window curtain was inherently flame retardant. Based on interview at the time of the observation, the Maintenance Assistant acknowledged window curtains installed in the 500 Hall shower room had no affixed documentation stating the window curtain was inherently flame retardant.</p> <p>3.1-19(b)</p> <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 2 of 2 extension cords including power strips were 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 15 residents, staff</p>	K010147	<p>property will be advised of prohibitions against them. D) The HFA will include observations for newly introduced fabrics on environmental rounds no less than once monthly. He will ensure the Maintenance Director continues to enforce prohibition of inappropriately fire-rated fabrics. Assigned staff members who fail to maintain compliance will be reprimanded.</p> <p>E) Date of Compliance with proposed actions: January 16, 2015</p> <p>K 147 <i>In response to cited findings, the following actions will be taken:</i> NFPA 101 LIFE SAFETY CODE STANDARD LSC 19.1.2 Fixed wiring. A) Appliances were unplugged from power strips and connected to wall outlets during the survey. B) All residents of the Memory Care and SNF Units could potentially be affected by</p>	01/16/2015			

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	<p>and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 10:55 a.m. to 1:30 p.m. on 01/02/15, the following was noted:</p> <p>a. two refrigerators were plugged into a power strip in the Memory Care Nurses Supply Room.</p> <p>b. a refrigerator was plugged into a power strip in the Dietary Manager's Office in the 400 Hall.</p> <p>Based on interview at the time of the observations, the Maintenance Director and Maintenance Assistant acknowledged power strips were being used as a substitute for fixed wiring at the aforementioned locations.</p> <p>3.1-19(b)</p>		<p>powerstrips/extension cords being utilized in the community.</p> <p>C) The Maintenance Director and/or his designee will perform monthly inspections with related documentation to monitor for improper power extension cords/strips being utilized in licensed portions of the community. Any found will be removed from the premises as indicated. Residents/family members who bring such items onto the property will be advised of prohibitions against them. D) The HFA will include observations for newly introduced extension cords/power stripson environmental rounds no less than once monthly. He will ensure the Maintenance Director continues to enforce prohibition of extension cords/powerstrips. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date ofCompliance with proposed actions: January 16, 2015</p>		