

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155586	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/04/2016
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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES	STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/04/2016</p> <p>Facility Number: 000283 Provider Number: 155586 AIM Number: 100275020</p> <p>At this Life Safety Code survey, Lutheran Life Villages 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>The main building is a three story, partially sprinklered building determined to be of Type I (332) construction with a basement. The Health and Rehabilitation building is a one story fully sprinklered building of Type I (332) construction. The main building has a fire alarm system with smoke detection in corridors, areas open to the corridors and hard</p>	K 0000	<p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in a couple of attachments as supportive documentation.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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K 0018 SS=E Bldg. 01	<p>wired smoke detectors in the resident rooms. The Health and Rehabilitation building has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detector in the resident rooms. The facility has a capacity of 213 and had a census of 118 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed on 04/08/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS</p>			

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	<p>regulations in all health care facilities. 19.3.6.3 Based on observation and interview, the facility failed to ensure 1 of 12 resident room corridor doors on D hall closed and latched into the door frame. This deficient practice could affect any of the 12 residents on D hall.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Director of Maintenance and the Life Safety Officer on 04/04/16 at 12:00 p.m., the corridor door to resident room 409 failed to latch into the door frame. Based on interview, this was acknowledged by the Director of Maintenance at the time of observations.</p> <p>3.1-19(b)</p>	K 0018	<p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation. K018 Corrective actions to be accomplished for those residents effected: No residents were directly affected by this deficient practice. The latch on room 409 was repaired on 4-12-16. All other resident room door latches were checked to assure they were functioning properly, and no other door latches failed to latch; this audit was completed by 4-15-2016. Other residents having the potential to be affected and the corrective actions: No residents were directly affected by this deficient practice. All other resident room doors latches were checked to assure they were functioning properly, and no other door latches failed to latch; this audit was completed by 4-15-2016. What measures were put into place to ensure</p>	05/04/2016	

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K 0020 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 Based on observation, the facility failed to ensure 2 of 2 vertical openings were protected as appropriate for the fire resistance rating of the barrier. LSC Section 8.2.5.2 requires openings through floors, such as stairways, to be enclosed	K 0020	this does not happen again: These doorlatches were last checked for proper functioning on 1-19-2016 per our PMprogram, with identified issues being corrected, and will continue to bechecked / corrected as appropriate/ audited on a semi-annual basis by theSafety Officer. How will the corrective actions bemonitored: These doorlatches were last checked for proper functioning on 1-19-2016 per our PMprogram with identified issues being corrected, and will continue to be checked/ repaired / audited on a semi-annual basis by the Safety Officer. The results of these audits will be reviewedat our monthly QA program on a semiannual basis. The Safety Officer will monitor forcompliance. The Director of Maintenancewill monitor for ongoing compliance. Please accept this as our credible allegation of compliance to ourrecent LSC annual survey. Submission of this Plan of Correction does notconstitute an admission or agreement by the provider of the truth of factsalleged or the corrections set	05/04/2016	

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	<p>with fire barrier walls. The passage of building service materials such as pipe shall be protected so that the space between the penetrating item and the fire barrier shall be filled with a material capable of maintaining the fire resistance of the fire barrier or be protected by an approved device designed for the specific purpose. This deficient practice affect all residents in the main building.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Director of Maintenance and the Life Safety Officer on 04/04/16 between 1:00 p.m. and 2:00 p.m., the following vertical openings had unsealed penetrations:</p> <p>a) On the second floor above the ceiling tiles by the stair door there were two unsealed half inch holes in the fire barrier of the west stairwell.</p> <p>b) On the third floor above the ceiling tiles by the stair door there was an unsealed one inch hole and a half inch unsealed penetration around a wire in the fire barrier of the west stairwell.</p> <p>c) On the third floor above the ceiling tiles by the stair door there was an unsealed one inch hole and a half inch unsealed penetration around a wire in the fire barrier of the east.</p> <p>Based on interview at the time of</p>		<p>forth on the statement of deficiencies.</p> <p>This Plan ofCorrection is prepared and submitted because of requirements under State &Federal Law. We are also scanning in several attachments as supportivedocumentation.</p> <p>K020</p> <p>Corrective actions to be accomplished forthose residents effected:</p> <p>No residents weredirectly affected by this deficient practice. The penetrations were sealed with the product (Boss products – 813Firestop). On the 2nd floorabove the ceiling tiles by the stair door, the 2 holes in the fire barrier weresealed on 4-9-2016. On the 3rdfloor above the ceiling tiles by the stair door - west, the 2 holes in the firebarrier were sealed on 4-9-2016. On the 3rd floor above the ceilingtiles by the stair door - east, the 2 holes in the fire barrier were sealed on4-9-2016. No other penetrations or holeswere found during the LSC annual inspection.</p> <p>Other residents having the potential to beaffected and the corrective actions:</p> <p>No residents weredirectly affected by this deficient practice. No other penetrations or holes were found</p>	

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K 0029 SS=E Bldg. 01	<p>observation, the Director of Maintenance acknowledged and provide the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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</p>		<p>during the LSC annual inspectionas each fire wall was inspected. Additionally, the Safety Officer inspects the fire walls on a semiannualbasis with a documented audit per policy.</p> <p>What measures were put into place toensure this does not happen again: No otherpenetrations or holes were found during the LSC annual inspection as each firewall was inspected. Additionally, theSafety Officer inspects the fire walls on a semiannual basis with a documentedaudit per policy.</p> <p>How will the corrective actions bemonitored: The fire wallsare inspected for holes or other penetrations on a semiannual basis, perpolicy, and per our PM program. Therresults of these audits will be reviewed at our monthly QA program on asemiannual basis. The Safety Officerwill monitor for compliance. TheDirector of Maintenance will monitor for ongoing compliance.</p>	

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	<p>extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 corridor doors to WPR-Craft Room used to store combustibles and measuring over 50 square feet in size was provided with a self-closing device. This deficient practice could affect up to 15 residents in the basement.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Director of Maintenance and the Life Safety Officer on 04/04/16 at 11:01 a.m., the corridor door to the WPR-Craft Room in the basement, which contained 40 cardboard boxes of paper and measuring over 50 square feet in size, lacked a self-closing device. Based on interview at the time of observation, this was acknowledged by the Director of Maintenance and the Life Safety Officer.</p> <p>3.1-19(b)</p>	K 0029	<p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies.</p> <p>This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supported documentation.</p> <p>K029</p> <p>Corrective actions to be accomplished for those residents effected:</p> <p>No residents were directly affected by this deficient practice. The corridor door to the WPR-Craft Room in the basement had a self-closing device installed on 4-7-2016. No other door closer issues were found during the LSC survey.</p> <p>Other residents having the potential to be affected and the</p>	05/04/2016

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			<p>corrective actions:</p> <p>No residents weredirectly affected by this deficient practice. All other doors, that store hazardous materials were inspected/ auditedto assure the proper self closing devices were in place. No other door closer issues were identifiedduring the LSC survey. Additionally, theSafety Officer inspected the doors and no other issues were found.</p> <p>What measures were put into place toensure this does not happen again:</p> <p>No other doorswere identified needing self closing devices during the LSC annualinspection. Additionally, the SafetyOfficer inspects all facility doors for appropriate and proper functioning on asemiannual basis with a documented audit which is reviewed in QA.</p> <p>How will the corrective actions bemonitored:</p> <p>The SafetyOfficer inspects all facility doors for appropriate and proper functioning on asemiannual basis with a documented audit. The results of these audits will be reviewed at our monthly QA programon a semiannual basis. The SafetyOfficer will monitor for compliance. TheDirector of Maintenance will monitor for</p>	

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K 0048 SS=F Bldg. 01	<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 provide a written plan that included the activation of a resident room battery operated smoke detector in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all residents in the Health and Rehabilitation center.</p> <p>Findings include:</p> <p>Based on a record review of the "Fire Procedure" with Director of Maintenance and the Life Safety Officer on 04/04/16 at</p>			K 0048	<p>ongoing compliance.</p> <p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation. K048 Corrective actions to be accomplished for those residents effected: No residents were directly affected by this deficient practice. The facility Fire Emergency Procedure was amended to include the use/activation of battery operated smoke detectors, (see attached K048) on 4-5-2016. Staff will be educated on this amendment by 4-29-2016 (see attached XX in service). Other residents having the potential to be affected and the corrective actions: No residents were directly affected by this deficient practice. The facility Fire</p>		05/04/2016

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K 0062 SS=F Bldg. 01	10:00 a.m., the plan did not address response to the activation of a resident room battery operated smoke detector. Based on interview, this was acknowledged by the Director of Maintenance at the time of record review. 3.1-19(b) 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,		Emergency Procedure was amended to include the use/activation of battery operated smoke detectors, (see attached K048) on 4-5-2016. Staff will be educated on this amendment by 4-29-2016 (see attached XX inservice). What measures were put into place to ensure this does not happen again: The facility Fire Emergency Procedure was amended to include the use/activation of battery operated smoke detectors, (see attached K048) on 4-5-2016. Staff will be educated on this amendment by 4-29-2016 (see attached XX inservice). How will the corrective actions be monitored: The Safety Officer conducts routine, monthly fire procedure drills in facility to practice & assure proper procedures are understood. Any issues that come up are addressed at our monthly safety committee meetings. The Safety Officer will monitor for compliance. The Administrator will monitor for ongoing compliance. Please find the following attachments: K048 Fire emergency procedure XX staff education/in service on 4-27-2016		

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	<p>NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 sprinkler gauges on the basement riser were tested every five years. NFPA 25, Section 2-3.2 states gauges shall be replaced every five years or tested every five years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all occupants in the main building.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Director of Maintenance and the Life Safety Officer on 04/04/16 at 10:30 a.m., the sprinkler gauge on the sprinkler riser by the riser room door in the basement had a date of 2010. Based on an interview and the time of observation, the Director of Maintenance was unable to verify if the sprinkler gauges had been calibrated within the last five years.</p> <p>3.1-19(b)</p>	K 0062	<p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies.</p> <p>This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation.</p> <p>K062</p> <p>Corrective actions to be accomplished for those residents effected:</p> <p>No residents were directly affected by this deficient practice. The sprinkler gauge in question, located in the basement was replaced on 4-5-2016. All other sprinkler gauges have been inspected / documented by Kooren's, and verified by Safety Officer 4-15-2016.</p> <p>Other residents having the potential to be affected and the corrective actions:</p> <p>No residents were directly affected by this deficient practice. No other sprinkler gauges were identified to be out of compliance during the LSC</p>	05/04/2016	

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			<p>inspection. All othersprinkler gauges have been inspected / audited / documented by Koorsen's, andverified by Safety Officer by 4-15-2016. Koorsen's conducts a quarterly inspection on the components of thefacility fire emergency systems; the facility Safety Officer will monitor thecompleteness of these inspections by Koorsens.</p> <p>What measures were put into place toensure this does not happen again: Koorsen'sconducts a quarterly inspection on the components of the facility fireemergency systems per code; additionally, the facility Safety Officer willmonitor the completeness, accuracy & timeliness of these inspections byKoorsens.</p> <p>How will the corrective actions bemonitored: Koorsen'sconducts a quarterly inspection on the components of the facility fireemergency systems per code; additionally, the facility Safety Officer willmonitor the completeness, accuracy & timeliness of these inspections byKoorsens. The results of these auditswill be reviewed at our monthly QA program on a semiannual basis. The Safety Officer will monitor forcompliance. The Director of Maintenancewill monitor for ongoing compliance.</p>	

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K 0075 SS=E Bldg. 01	<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 soiled linen or trash collection receptacles was not exceeded within any 64 square feet area for 3 of 8 corridors. This deficient practice could affect up to 55 residents in the health and rehabilitation building.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Director of Maintenance and the Life Safety Officer on 04/04/16 between 12:13 p.m. 1:11 p.m., two or more adjacent containers of biohazardous soiled linens and biohazardous trash totaling more than 32 gallon were discovered at the following locations:</p> <p>a) In the corridor of " A " hall b) In the corridor of " C " hall</p>	K 0075	<p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies.</p> <p>This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supported documentation.</p> <p>K075</p> <p>Corrective actions to be accomplished for those residents effected:</p> <p>No residents were directly affected by this deficient practice. The linen and trash containers for A Hall, B Hall and from the Tulip shower room</p>	05/04/2016

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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES	STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816
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	<p>c) In the Tulip shower room which was not equipped with a self-closer. Based on an interview at the time of observation, the Director Maintenance Acknowledge the soiled linen containers were being stored in the corridor and in a room without a self-closer.</p> <p>3.1-19(b)</p>		<p>were removed on 4-4-2016. Nooter areas were indentified to be out of compliance during the LSCinspection. Nursing staff were verballyeducated on this specific issue. NurseManagers also made rounds to assure there were no other issues, ongoing.</p> <p>Other residents having the potential to beaffected and the corrective actions:</p> <p>No residents weredirectly affected by this deficient practice. The linen and trash containers for A Hall, B Hall and from the Tulipshower room were removed on 4-4-2016. Nooter areas were indentified to be out of compliance during the LSCinspection. Nursing staff were verballyeducated on this specific issue on 4-4-2016. Safety Officer communicated with the DON on the issues indentified duringthe LSC audit on 4-6-2016. NurseManagers also conduct daily rounds to assure there were no other complianceissues.</p> <p>What measures were put into place toensure this does not happen again:</p> <p>Nursing staffwere verbally educated on this specific issue on 4-4-2016. Safety Officer communicated with the DON onthe issues indentified during the LSC audit on 4-6-2016. A staff inservice will be presented on April27, 2016, regarding this issue (see attachment XX). Safety Officer will conduct weekly roundsthrough</p>	

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K 0076 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.		the end of May 2016, and monthly thereafter. Nurse Managers conduct rounds daily, several times a day & will also monitor for compliance. How will the corrective actions bemonitored: Safety Officer will conduct weekly rounds through the end of May 2016, and monthly thereafter. Nurse Managers conduct rounds daily, several times a day & will also monitor for compliance -ongoing. The results of these audits will be reviewed at our monthly QA program, addressing any issues. The Nurse Managers will monitor for compliance. The Director of Nursing and Safety Officer will monitor for ongoing compliance. Please find the following attachments: XX Staff in service/education on 4-27-2016	

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	<p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen cylinders in room 326 and 2 of 2 oxygen cylinders in the Assistant Director of Nursing Office were properly restrained. NFPA 99, Section 8-3.1.11.2(h) requires cylinder restraint to meet the requirements of Section 4-3.5.2.1(b) 27 which requires freestanding cylinders to be chained or supported in a cylinder stand or cart. This deficient practice could affect 2 residents in room 326 and up to 15 residents in or outside of the Assistant Director of Nursing Office.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Director of Maintenance and the Life Safety Officer on 04/04/16 between 12:15 p.m. and 12:55 p.m., there was an unsupported "E" cylinder of compressed oxygen in room 326 of the Health and Rehabilitation Center, and two unsupported "E" cylinders of compressed oxygen on a counter in the Assistant Director of Nursing Office. Based on interview at the time of observation, this was acknowledged by the Director of Maintenance and the Life Safety Officer.</p>	K 0076	<p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies.</p> <p>This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supported documentation.</p> <p>K076</p> <p>Corrective actions to be accomplished for those residents effected:</p> <p>No residents were directly affected by this deficient practice. The E cylinder of compressed oxygen tank from room 326 and the 2 tanks that were found in the ADON office were removed and stored correctly on 4-4-16. The 2 tanks in question in the ADON office, were empty and were left there to be sent back to the company; staff now know to put all tanks, supported correctly, in the Oxygen room regardless of their condition. No other E cylinder tanks were found stored incorrectly & out</p>	05/04/2016

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	3.1-19(b)		<p>of compliance during the LSC inspection. Nursing staff were verbally educated on this specific issue. Nurse Managers also made rounds to assure there were no other issues of incorrectly stored E cylinder tanks.</p> <p>Other residents having the potential to be affected and the corrective actions: No residents were directly affected by this deficient practice. The 2 tanks in question in the ADON office, were empty and were left there to be sent back to the company; staff now know to put all tanks, supported correctly, in the Oxygen room regardless of their condition. No other E cylinder tanks were found stored incorrectly & out of compliance during the LSC inspection. Nursing staff were verbally educated on this specific issue. Nurse Managers also made rounds to assure there were no other issues of incorrectly stored E cylinder tanks.</p> <p>What measures were put into place to ensure this does not happen again: Nursing staff were verbally educated on this specific issue on 4-4-2016. Safety Officer communicated with the DON on the issues identified during the LSC audit on 4-6-2016. A staff in service will be presented on April 27, 2016, regarding this issue (see attachment XX). Safety Officer</p>	

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K 0130 SS=F Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 fire barrier walls in the Health and Rehabilitation Center was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to	K 0130	will conduct weekly roundsthrough the end of May 2016, and monthly thereafter. Nurse Managers conduct rounds daily, severaltimes a day & will also monitor for compliance. How will the corrective actions bemonitored: Safety Officerwill conduct weekly rounds through the end of May 2016, and monthlythereafter. Nurse Managers conductrounds daily, several times a day & will also monitor for compliance -ongoing. The results of these audits will be reviewed at our monthly QAprogram, addressing any issues. TheNurse Managers will monitor for compliance. The Director of Nursing and Safety Officer will monitor for ongoingcompliance. Please find the following attachments: XX Staffinservice/education on 4-27-2016 Please accept this as our credible allegation of compliance to ourrecent LSC annual survey. Submission of this Plan of Correction does notconstitute an admission or agreement by the provider of the truth of factsalleged or the corrections set	05/04/2016	

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	<p>minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect all residents in the Health and Rehabilitation Center.</p> <p>Findings include:</p>		<p>forth on the statement of deficiencies.</p> <p>This Plan ofCorrection is prepared and submitted because of requirements under State &Federal Law. We are also scanning in several attachments as supportivedocumentation.</p> <p>K130</p> <p>Corrective actions to be accomplished forthose residents effected:</p> <p>No residents weredirectly affected by this deficient practice. Regarding the fire barrier separating the assisted living and thehealthcare center on D wing, the gap identified during the LSC inspection wascorrected / sealed with the product (Boss products – 813 Firestop) on 4-16-16. No other gaps were found during the LSCannual inspection or identified by the LLV Safety Officer.</p> <p>Other residents having the potential to beaffected and the corrective actions:</p> <p>No residents weredirectly affected by this deficient practice. The penetrations from tag F020 had also been corrected with no otherpenetrations or holes found during the LSC annual inspection as each fire wallwas inspected. Additionally, the SafetyOfficer</p>	

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K 0147 SS=D Bldg. 01	<p>Based on an observation during a tour of the facility with the Director of Maintenance and the Life Safety Officer on 04/04/16 at 1:30 p.m., the fire barrier separating assistive living and the Health and Rehabilitation Center terminated one inch below the top part of the corrugated roof deck, and the gaps between the fire barrier and the corrugated roof deck were not sealed. Based on interview at the time of observation, the Director of Maintenance acknowledge the gaps between the fire wall and corrugated roof decking, and confirmed the wall was a fire barrier.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 2 of 2 flexible</p>	K 0147	<p>inspects the fire walls on a semiannual basis with a documented audit per policy.</p> <p>What measures were put into place to ensure this does not happen again: No other gaps in the fire walls were identified during the LSC annual inspection as each firewall was inspected. Additionally, the Safety Officer inspects the fire walls on a semiannual basis with a documented audit per policy.</p> <p>How will the corrective actions be monitored: The fire walls are inspected for holes, gaps or other penetrations on a semiannual basis, per policy, and per our PM program. The results of these audits will be reviewed at our monthly QA program on a semiannual basis. The Safety Officer will monitor for compliance. The Director of Maintenance will monitor for ongoing compliance.</p> <p>Please accept this as our credible allegation of compliance to our recent LSC annual survey.</p>	05/04/2016

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	<p>cords such as extension cord power strips were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. 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 was not in a resident care area but could affect all staff in the medical records room.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Director of Maintenance and the Life Safety Officer on 04/04/16 at 10:50 a.m., an extension cord power strip was plugged in and providing power to another extension cord power strip which was providing power to IT equipment in the medical records office. Based on interview at the time of observation, the Director of Maintenance acknowledged the power strips were plugged into one another.</p> <p>3.1-19(b)</p>		<p>Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the corrections set forth on the statement of deficiencies.</p> <p>This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supported documentation.</p> <p>K147</p> <p>Corrective actions to be accomplished for those residents effected:</p> <p>No residents were directly affected by this deficient practice. The 2 extension power cords were removed on 4-4-2016 by the Maintenance Director. Nurse Managers inspected all other rooms on 4-4-2016, looking for noncompliance with extension power cords, taking the appropriate action to assure compliance. The Safety Officer also made rounds on 4-4-16, inspecting rooms for noncompliance and taking the appropriate actions to assure compliance.</p> <p>Other residents having the potential to be affected and the corrective actions:</p>	

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			<p>No residents were directly affected by this deficient practice. Nurse Managers inspected all other rooms on 4-4-2016, looking for noncompliance with extension power cords, taking the appropriate action to assure compliance. The Safety Officer also made rounds on 4-4-16, inspecting rooms for noncompliance and taking the appropriate actions to assure compliance.</p> <p>What measures were put into place to ensure this does not happen again:</p> <p>Nursing staff were verbally educated on this specific issue on 4-4-2016. Safety Officer communicated with the DON on the issues identified during the LSC audit on 4-6-2016. A staff in service will be presented on April 27, 2016, regarding this issue (see attachment XX). Safety Officer will conduct weekly rounds through the end of May 2016, and monthly thereafter. Nurse Managers conduct rounds daily, several times a day & will also monitor for compliance.</p> <p>How will the corrective actions be monitored:</p> <p>Safety Officer will conduct weekly rounds through the end of May 2016, and monthly thereafter. Nurse Managers conduct rounds daily, several times a day & will also monitor for compliance - ongoing. The results of these audits will be</p>	

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			<p>reviewed at our monthly QA program, addressing any issues. The Nurse Managers will monitor for compliance. The Director of Nursing and Safety Officer will monitor for ongoing compliance.</p> <p>Please find the following attachments: XX Staff in service/education on 4-27-2016</p>		