

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155178	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/17/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
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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: 08/17/15</p> <p>Facility Number: 000094 Provider Number: 155178 AIM Number: 100290310</p> <p>At this Life Safety Code survey, Golden Living Center-Fountainview 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 with partial basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 130 and had a census of</p>	K 0000	<p>Preperation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of the deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. We respectfully submit this document as our Plan of Correction for the alleged deficiencies as outlined. We respectfully request Desk Compliance .</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>88 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, except for the maintenance shed used for storage.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 4 of 68 resident room corridor doors closed and latched into the door frame. This deficient practice could affect 11 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 08/17/15 between 12:11 p.m. and 1:32</p>	K 0018	<p>It is the intent of this facility to ensure all resident room corridor doors close and latch into the door frame. This deficient practice could affect 11 residents. Corrective action for those affected: following the survey the Maintenance Director adjusted the hinges and tested the doors to on room(s) 118, 201, 207, and 218. A contractor will be secured to review and adjust all resident</p>	09/16/2015

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K 0025 SS=E Bldg. 01	p.m., the Maintenance Supervisor acknowledged the corridor door to resident rooms 118, 201, 207, 218 failed to latch into the frame when tested. 3.1-19(b) 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		room corridor doors to assure the doors close and latch into the door frame. Any identified concern will be reported to the Executive Director immediately for correction. The Maintenance Director or Designee will add to the preventive maintenance schedule a regularly scheduled audit of all resident room corridor doors to assure the doors close and latch into the door frame. Any identified concern will be reported to the Executive Director immediately for correction. Staff in all departments will be educated to this requirement. Residents and families will be educated to this requirement. The Maintenance Director or Designee will conduct audits of resident room corridors as outlined above weekly for 4 weeks; every other week for 4 weeks; monthly for 4 months. Results of these audits will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.	

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	<p>protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 1 of 1 smoke barrier walls were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect all staff and up to 49 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 08/17/15 from 10:51 a.m. to 2:10 p.m., the following smoke barrier wall penetration and unsealed ceiling penetrations were noted:</p> <ul style="list-style-type: none"> a) a half inch ceiling penetration in the Data Room b) a half inch ceiling penetration in the 100 Hall Medication Room c) a half inch smoke barrier penetration near resident room 112 d) a half inch smoke barrier penetration around cable near resident room 104 e) two separate eighth inch penetration 	K 0025	<p>It is the intent of this facility to ensure ceiling smoke barriers and smoke barrier walls are maintained to provide a one half hour fire resistance rating and that smoke barriers shall be continuous from an outside wall to an outside wall. Corrective action for resident(s) in room # 112, 104, 226 and 211 have been requested to relocate to other areas of the facility. Resident 112 bed 1 and both residents residing in room 104 have refused to be relocated. 49 residents have the potential to be affected. A licensed contractor will be engaged to inspect all areas of the ceiling smoke barrier and smoke barrier walls to assure there are no gaps in the barrier(s). Any further areas of concern will be identified and corrected. Staff in all departments will participate in increased fire drills to ensure the awareness of safety procedures when identifying smoke or fire in the facility, and that the environment remains free of accident hazards as possible and that each resident receives adequate supervision and assistance as needed. The areas</p>	09/16/2015

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K 0046 SS=E Bldg. 01	<p>around cables and a three inch gap around wires near resident room 226 f) a half inch gap in a pipe around cables by resident room 211 Based on interview at the time of each observation, the Maintenance Director acknowledged and provided the measurements for each unsealed penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1. Based on interview and observation, it was determined that the facility failed to</p>	K 0046	<p>of the identified gaps in the ceiling smoke barriers and the smoke barrier walls will be reported to the local fire department for awareness. The local fire department will be contacted and a date will be set for an "active" training on the use of the fire extinguisher, safety when identifying smoke or fire in the facility, and fire safety for all staff, residents and families. Maintenance Director of the facility will monitor the inspection and repair of the ceiling smoke barriers and smoke barrier walls. Any further concerns identified will be reported to the Administrator immediately for correction. A report of the inspection and work completed will be forwarded to the Indiana State department of Health. Results of these corrections will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.</p> <p>It is the intent of this facility to provide exterior emergency</p>	09/16/2015	

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	<p>provide exterior emergency lighting for 14 of 14 exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all occupants in the facility including staff, visitors and residents if the facility were required to evacuate in an emergency and the generator was providing electricity at that time.</p> <p>Findings include:</p> <p>Based on observation and interview with the Maintenance Director on 08/17/15 at 11:19 a.m., it was unknown if the exterior lights for the exit discharge for all of the facility exits were connected to the generator.</p> <p>3.1-19(b)</p>		<p>lighting for means of egress for the exit access and exit discharge. to assure safety of staff, visitors and residents if the facility were required to evacuate in an emergency and the generator was providing electricity at that time. All residents have the potential to be affected. Corrective action for all residents: the evening of the exit survey a generator load test was conducted. The exterior emergency lighting was confirmed to come on at all 14 of 14 exits, and stay engaged for a minimum of 1 and one-half hour of duration. The breaker for these lights located in the main electrical room was monitored as well and received power when full transfer was made. The Maintenance Director will run regularly scheduled tests of the emergency generator, after dark, and the exterior lighting of the the 14 exits to assure working condition. These tests will be a part of the preventive maintenance at the facility and will be logged and maintained for review. Staff in all departments will be educated on requirement to note any lighting not present at the 14 exits and report that to the Maintenance Director to ensure environment remains free of accident hazards as possible The Maintenance Director will report to the Executive Director any concerns with the generator or the emergency lighting</p>		

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K 0050 SS=B Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all staff, residents, and visitors.</p> <p>Findings include:</p>	K 0050	<p>immediately for correction. The Maintenance Director or Designee will run regularly scheduled tests of the emergency generator, after dark, and the exterior lighting of the the 14 exits to assure working condition weekly for 4 weeks; every other week for 4 weeks; monthly for 4 months. Results of these audits will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.</p> <p>It is the intent of this facility to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. All residents have the potential to be affected. Corrective action for all residents: the Maintenance Director will write a monthly plan to assure fire</p>	09/16/2015	

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K 0062 SS=D Bldg. 01	<p>Based on record review of the "Report of Monthly Fire Drill" forms with the Maintenance Director on 08/17/15 at 9:28 a.m., three of four last four quarter third shift fire drills took place between 5:15 a.m. and 5:40 a.m., three of four last four quarter second shift fire drills took place between 3:00 p.m. and 4:00 p.m., and three of four last four quarter first shift drills took place between 10:00 a.m. and 10:48 a.m. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are</p>		<p>drills are conducted at unexpected times each month, to include all 3 shifts each quarter. Staff in all departments will be educated as any concerns arise during these drills. The Maintenance Director will report to the Executive Director any concerns with the drills immediately for correction. The local fire department will be contacted and a date will be set for an "active" training on the use of the fire extinguisher and fire safety for all staff, residents and families. The Maintenance Director or Designee will conduct fire drills at unexpected days of the week and times of the day each month to educate staff and assure safety measures are in place. These drills will be logged and maintained for review. The Maintenance Director or Designee will conduct fire drills as outlined above weekly for 4 weeks; every other week for 4 weeks; monthly for 4 months. Results of these audits will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.</p>		

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	<p>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 replace 1 of 1 corroded sprinkler head in the Food Service Office Storage Room and 1 of 16 painted sprinkler heads in Therapy. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff and any visitors or residents in Therapy.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 08/17/15 at 11:03 a.m. then again at 1:47 p.m., a sprinkler head in the Food Service Office Storage Room was corroded. Then again a sprinkler head in Therapy was painted. Based on interview at the time of each observation, the Maintenance Director acknowledged the aforementioned condition.</p>	K 0062	<p>It is the intent of this facility to assure all automatic sprinkler systems shall be inspected and maintained, and that any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff and any visitors or residents in Therapy. A licensed contractor will be engaged to inspect all sprinkler heads in the facility and will be contracted to replace all corroded and painted sprinkler heads. Maintenance Director of the facility will monitor the inspection and replacement of the corroded and painted sprinkler heads. Any further concerns identified will be reported to the Administrator immediately for correction. A report of the inspection and work completed will be forwarded to the Indiana State department of Health. The Maintenance Director or Designee will audit the integrity of the sprinkler heads weekly for 4 weeks; every other week for 4 weeks; monthly for 4 months. Results of these audits will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure</p>	09/16/2015			

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K 0069 SS=D Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to protect cooking equipment with a range hood extinguishing system in accordance with LSC Sections 9.2.3 and 19.3.2.6 and NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations in 1 of 4 pantry kitchens. NFPA 96, 7-1.2 requires cooking equipment that produces grease laden vapors (such as but not limited to deep fat fryers, ranges, griddles, broilers, woks, tilting skillets, and braising pans) shall be protected by fire extinguishing equipment. This deficient practice could affect any resident, as well as staff and visitors using the Activities Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 08/17/15 at 11:24 a.m., there was a stovetop in the Activity Room. Based on interview at the time of observation, the Maintenance Director was asked what was cooked on</p>	K 0069	<p>corrective action for this deficient practice has been accomplished.</p> <p>It is the intent of this facility to protect cooking equipment with a range hood extinguishing system. This deficient practice could affect any resident, as well as staff and visitors using the Activities Room. Residents do not and will not use the Activity Kitchen area without staff supervision. Residents and staff will be educated on this deficient practice. The local fire department will be contacted and a date will be set for an "active" training on the use of the fire extinguisher, safety when identifying smoke or fire in the facility, and fire safety for all staff, residents and families. This cook stove will not be utilized to prepare any food item that produces grease laden vapors. Equipment such as but not limited to deep fat fryers, ranges, griddles, broilers, woks, tilting skillets, and braising pans will not be used in this area. Any and all food preparation in this area will be discussed during the morning IDT meeting for review and approval as outlined above. Activities Director of the facility or Designee will monitor the use of the Activity room kitchen area at all times when in use. Any further</p>	09/16/2015

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K 0130 SS=E Bldg. 01	<p>the stove top or in the oven. The Maintenance Director claimed that "ground beef" was cooked just the other day. The Maintenance Director confirmed that the Activity Room stove was not under a hood system with an extinguishing system and acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation and interview, the facility failed to ensure the penetration in 1 of 3 fire barrier walls 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 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: (1) The space between the penetrating</p>	K 0130	<p>concerns identified will be reported to the Administrator immediately for correction. The Activities Director or Designee will audit the use of the Activity Room kitchen area weekly for 4 weeks; every other week for 4 weeks; monthly for 4 months. Results of these audits will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.</p> <p>It is the intent of this facility to ensure the penetration of fire barrier walls is maintained to ensure the fire resistance of the barrier. This deficient practice could affect residents in 3 of 11 smoke compartments. A licensed contractor will be engaged to inspect all areas of the facilities fire barrier walls to assure the integrity of the wall is intact. Any further areas of concern will be identified and corrected. Staff in all departments will participate in increased fire drills to ensure the awareness of safety procedures when identifying smoke or fire in the facility, and that the environment remains free of</p>	09/16/2015			

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	<p>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 residents in 3 of 11 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 08/17/15 at 2:01 p.m. then again at 2:16 p.m., the fire barrier wall entering 100 Hall had five unsealed penetrations measuring a quarter of an inch to a four by three quarter inch penetration. Then again the Main Lobby fire barrier wall had a half inch unsealed penetration in a tub around</p>		<p>accident hazards as possible and that each resident receives adequate supervision and assistance as needed. The areas of the identified concerns for the integrity of the fire barrier walls will be reported to the local fire department for awareness. The local fire department will be contacted and a date will be set for an "active" training on the use of the fire extinguisher, safety when identifying smoke or fire in the facility, and fire safety for all staff, residents and families. Maintenance Director of the facility will monitor the inspection and repair of the fire barrier walls. Any further concerns identified will be reported to the Administrator immediately for correction. A report of the inspection and work completed will be forwarded to the Indiana State department of Health. Results of these corrections will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.</p> <p>It is the intent of this facility to complete a written record of the annual inspection and testing of the rolling fire doors. This deficient practice could affect any residents present in the dining room adjacent to the kitchen</p>	

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
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	<p>cables. Based on interview at the time of each observation, the Maintenance Director acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any residents present in the dining room adjacent to the kitchen including staff or visitors.</p> <p>Findings include:</p>		<p>including staff or visitors. A licensed contractor will be engaged to inspect all areas of the rolling fire doors in question. This contractor will be secured to make all repairs necessary to assure working order and safety of this device. Any further areas of concern will be identified and corrected. Staff in all departments will participate in increased fire drills to ensure the awareness of safety procedures when identifying smoke or fire in the facility, and that the environment remains free of accident hazards as possible and that each resident receives adequate supervision and assistance as needed. The concern for the "rolling" fire door will be reported to the local fire department for awareness. The local fire department will be contacted and a date will be set for an "active" training on the use of the fire extinguisher, safety when identifying smoke or fire in the facility, and fire safety for all staff, residents and families. Maintenance Director of the facility will monitor the inspection and repair of the rolling fire wall. Any further concerns identified will be reported to the Administrator immediately for correction. A report of the inspection and work completed will be forwarded to the Indiana State department of Health. The Maintenance Director or Designee will run regularly</p>	

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K 0143 SS=E Bldg. 01	<p>Based on observation with the Maintenance Director on 08/17/15 at 11:13 a.m. there was a rolling fire door protecting the opening from the kitchen to the lounge room with an attached inspection tag dated for 5/13/14. The dining room was open to the corridor. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not</p>		<p>scheduled tests of the rolling fire door to assure working condition weekly for 4 weeks; every other week for 4 weeks; monthly for 4 months. Results of these tests will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished. Results of these corrections will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.</p>		

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	<p>permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 liquid oxygen storage areas where oxygen transferring takes place, was provided with continuous mechanical ventilation. This deficient practice could affect staff and 48 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 08/17/15 at 12:18 p.m. then again at 1:36 p.m. 100 Hall then 200 Hall oxygen storage/transfer rooms were provided with a mechanically operated fan/vent but were not working. Based on interview at the time of each observation, the Maintenance Director acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p>	K 0143	<p>It is the intent of this facility to ensure that oxygen storage areas where oxygen transferring takes place, is provided with continuous mechanical ventilation. This deficient practice could affect staff and 48 residents. Corrective actions: Immediately following the exit for this survey, the Maintenance Director repaired and made operational one of two exhaust fans. Another exhaust fan was ordered and will be installed immediately upon acquisition. Staff will be educated on the importance of the continuous ventilation in these oxygen storage areas and what to look for to assure they are operational. Any concerns will be reported to the Maintenance Director. The Maintenance Director or Designee will run regularly scheduled audits of the continuous mechanical ventilation to assure working condition weekly for 4 weeks; every other week for 4 weeks; monthly for 4 months. Results of these audits will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.</p>	09/16/2015

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K 0147 SS=E Bldg. 01	<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 3 of 3 multiplugs and 18 of 18 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 13 residents.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Director on 08/17/15 between 10:51 a.m. to 1:17 p.m. the following was discovered:</p> <ul style="list-style-type: none"> a) a multiplug adapter powering data equipment in the Data Room b) a surge protector powering a refrigerator in the Environmental Services office c) an extension cord powering a stored air compression in the Maintenance Office d) a multiplug powering a bug light and a WanderGuard without an outlet cover 	K 0147	<p>It is the intent of this facility to ensure that flexible cords and cables shall not be used as a substitute for fixed wiring. This deficient practice affects staff and up to 13 residents. Corrective action for all residents: a room audit was completed following this survey. Residents in rooms 103,104,107,108, 109, 112, 113,114, 115, 116,117,119,120,122, 123, 124, 127, 129, 130,131, 135, 206, and 218 has been accomplished by removing all power extension cords. A licensed electrician will be contracted to survey the facility to assist in identifying any other areas that may be affected by this deficiency, and secured to make all needed to correction to being facility up to code, and provide for the needs of the residents without the use of flexible cords or cables. Staff, residents and families will be educated on the safety awareness for this deficiency and requested compliance for not using the flexible cords or cables without the awareness of the Maintenance Director, or other staff. Any concerns will be reported to the Maintenance Director or Executive Director. The Maintenance Director or Designee will conduct regularly</p>	09/16/2015

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	<p>above the Kitchen entrance</p> <p>e) a surge protector powering another surge protector powering lift batteries in the 100 Hall Utility Room</p> <p>f) a surge protector powering a microwave in the 100 Hall Nutrition Pantry</p> <p>g) a surge protector powering a surge protector powering a refrigerator in the 100 Hall Medication Room</p> <p>h) a surge protector powering an oxygen concentrator in resident room 113</p> <p>i) a surge protector powering a refrigerator in resident room 115</p> <p>j) a surge protector powering a refrigerator in resident room 118</p> <p>k) a surge protector powering a refrigerator in resident room 130</p> <p>l) a surge protector powering an oxygen concentrator and a surge protector powering a refrigerator in resident room 131</p> <p>m) a multiplug powering a copier in the Business office</p> <p>n) a surge protector powering a refrigerator and an extension cord powering an air conditioner in the Executive Director's office</p> <p>o) a surge protector powering an oxygen concentrator in resident room 206</p> <p>p) a surge protector powering another surge protector in resident room 215</p> <p>Based on interview at the time of observation, the Maintenance Director</p>		<p>scheduled audits of the resident rooms and the office areas to assure no cables or flexible cords are used inappropriately. weekly for 4 weeks; every other week for 4 weeks; monthly for 4 months. Results of these audits will be reviewed and discussed in monthly Quality Assurance Performance Improvement (QAPI) meeting through February 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.</p>	

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	acknowledged each aforementioned condition. 3.1-19(b)				