

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155423	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/12/2012
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NAME OF PROVIDER OR SUPPLIER  HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/12/12</p> <p>Facility Number: 000365 Provider Number: 155423 AIM Number: 100287460</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hammond-Whiting Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully</p>	K0000	<p>Please reference the enclosed 2567-L as "Plan of Correction" for the March 12, 2012 Life Safety Code Survey that was conducted at Hammond Whiting Care Center. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to our Elders in our community. The Plan of Correction submitted on March 31, 2012 serves as our allegation of compliance. Should you have any question or concerns regarding the Plan of Correction, please contact me. We would like to respectfully request a desk review.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>sprinklered. The facility has a fire alarm system with smoke detection in the corridors and resident sleeping rooms. The facility has the capacity for 80 and had a census of 64 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/16/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidence by:</p>			

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K0018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 4 smoke compartments were equipped with positive latches and were not prevented from closing. This deficient practice affects staff, visitors and 40 or more residents in the dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 03/12/12 at 3:45 p.m., two double french door sets protected the corridor openings to two resident dining rooms. Only one</p>	K0018	<p>1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u> No resident was immediately affected by this deficient practice</p> <p>2. <u>How the facility will identify other residents potentially affected by the same alleged deficient practice:</u> No other residents were immediately affected by this deficient practice</p> <p>3. <u>What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur:</u> Door sweeps were placed on the bottom of the doors to allow the doors to stay open until closed by staff. We are seeking bids from two vendors to equip the doors with positive latches. Work will be completed as soon as possible from one of the two vendors, all efforts will be made to complete the work by</p>	04/10/2012	

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	<p>door in each door set latched into the door frame. The second door in each set required the first door to latch before it could be latched into the first door. In addition, one door in each of the door sets was prevented from closing by a straight back chair placed in front of the open door. The maintenance supervisor acknowledged at the time of observations, each door could not latch independently and were prevented from closing.</p> <p>3.1-19(b)</p>		<p>4/10/12. 4. <u>How corrective actions will be monitored to ensure the alleged deficient practice will not recur:</u> The Maintenance Supervisor / designee will audit the doors on his weekly rounds for three months to assure that the doors latch properly and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase / decrease the number of audits and frequency of audits.</p>		

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K0021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 8 doors to hazardous areas such as a storage room larger than 50 square feet and a boiler/ maintenance room were held open only by devices which would allow the doors to close upon activation of the fire alarm system. This deficient practice affects visitors and 40 residents in the South Hall and 10 or more staff in the South Hall and Service Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 03/12/12 between 12:15 p.m.</p>	K0021	<p>1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u> On 3-12-12 the Maintenance director removed the door stop in the boiler room and removed the pill bottle in the central supply room. 2. <u>How the facility will identify other residents potentially affected by the same alleged deficient practice:</u> No other residents were immediately affected by this deficient practice 3. <u>What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur:</u> Staff members from all departments were in-serviced by the Executive Director on 3/29/2012 in regards to not propping doors open. Maintenance Supervisor will add to his weekly rounds list to verify no doors are being propped open.</p>	04/10/2012	

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	and 4:15 p.m., the corridor door to the unoccupied Central Supply storage room was held open by a cardboard box at 12:30 p.m. and a pill bottle at 3:55 p.m. placed in front of the door to prevent closing, the door to the boiler room/maintenance shop was held open by a wooden wedge at 12:20 p.m. and 3:45 p.m. The maintenance supervisor acknowledged the doors would not close automatically when the fire alarm system was activated.  3.1-19		4. <u>How corrective actions will be monitored to ensure the alleged deficient practice will not recur:</u> The maintenance Supervisor or designee will audit doors weekly for three months to ensure that there are no doors being propped open and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase / decrease the number of audits and frequency of audits.		

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K0025 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>Based on observation and interview, the facility failed to ensure openings through smoke barriers in 2 of 4 smoke compartments was protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors, staff and 50 or more residents in the North and Center smoke compartments.</p>	K0025	<p>1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u> On 3-20-12, the Maintenance director applied a fire rated calk to fill the gap around the pipe in the attic. 2. <u>How the facility will identify other residents potentially affected by the same alleged deficient practice:</u> No other residents were immediately affected by this deficient practice. 3. <u>What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur:</u> The Maintenance Supervisor will conduct a monthly audit to ensure all penetrations are filled properly. 4. <u>How corrective actions will be monitored to ensure the alleged deficient practice will not recur:</u> The maintenance Supervisor or designee will audit monthly for three months and provide the Executive Director with the results of those audits</p>	04/10/2012			

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	<p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 03/12/12 at 4:20 p.m., a one inch pipe penetrated the north smoke barrier above the ceiling above the smoke barrier doors separating the North Hall and Center smoke compartments. The resulting half inch annular gap was not sealed. The maintenance supervisor acknowledged at the time of observation, the gap should have been sealed.</p> <p>3.1-19(b)</p>		<p>monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase / decrease the number of audits and frequency of audits.</p>		

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to provide automatic door closers on 3 of 8 doors providing access to hazardous areas. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors and 4 or more in the service corridor and 40 or more residents accessing the adjacent dining rooms.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance supervisor on 03/12/12 at 3:40 p.m., the three by three foot opening between the</p>	K0029	<p>1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u> On 3-27-12, Overhead Door Service was contacted to install a self-closing roll up fire door on the kitchen window. The Maintenance Supervisor repaired the self-closer on the laundry room door and the access door to the dietary food storage room. The Maintenance Supervisor repaired the gap on the double doors for the laundry room. 2. <u>How the facility will identify other residents potentially affected by the same alleged deficient practice:</u> No other residents were immediately affected by this deficient practice 3. <u>What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur:</u> Staff members from all departments were in-serviced by the Executive Director on 3/29/2012 in regards to doors being closed properly.</p>	04/10/2012			

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	<p>dining room and kitchen dishwashing area was protected by a metal door which was secured wide open by a slide bolt latch. The maintenance supervisor said at the time of observation, the door was not self closing. To close the door, staff had to go into the dining room, open the latch and pull the metal door down. He said this was done when the kitchen closed each evening. He said the door was not closed when fire drills were practiced.</p> <p>b. Based on observation with the maintenance supervisor on 03/12/12 at 3:30 p.m., the single access door to the laundry would not close automatically because the self closer had been dismantled.</p> <p>c. Based on observation with the maintenance supervisor on 03/12/12 at 3:10 p.m., the access door to the ten by twelve foot dietary food storage room had no self closing device. The maintenance supervisor acknowledged at the time of observations, these doors were not self closing.</p>		<p>Work will be completed as soon as possible by Overhead Door Service, every effort will be made to complete the work by 4/10/12. 4. <u>How corrective actions will be monitored to ensure the alleged deficient practice will not recur:</u> The Maintenance Supervisor will add to his weekly facility rounds checklist the monitoring of all doors to ensure that the doors are not blocked and latch properly. The audits will be completed weekly for a month then monthly for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase / decrease the number of audits and frequency of audits.</p>		

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure doors to 1 of 8 hazardous areas could resist the passage of smoke. LSC requires where hazardous areas are protected by the approved automatic fire extinguishing system, the hazardous area is separated from other spaces by smoke resisting partitions and doors. This deficient practice could affect 10 or more staff and any visitors in the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 03/12/12 at 3:30 p.m., the self closing double doors providing access to the laundry gapped one half inch between the doors when closed. The maintenance supervisor acknowledged at the time of observation these doors could not resist the passage of smoke.</p> <p>3-1. 19(b)</p>				

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K0046 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review and interview, the facility failed to ensure documentation was complete for 30 second monthly testing for 18 of 18 battery powered emergency lighting fixtures and the fixtures were tested annually for 1 1/2 hours. LSC 7.9.3 requires an annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours and a monthly test for 30 seconds. Written records of visual inspections and tests shall be kept. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on review of facility fire safety inspection and preventive maintenance records with the maintenance supervisor on 03/12/12 between 12:15 and 4:45 p.m., 30 second monthly checks were recorded on a computer TELS printout. The document noted "yes" for testing battery powered emergency light fixtures, however, there was no list for each device, it's location and performance. In addition, there was no record of an annual 1 1/2 hour test for any</p>	K0046	<p>1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u> On 3-19-12 the Maintenance director conducted a facility wide inspection to list and identify all battery powered emergency lighting and developed a chart for documentation of monthly checks. 2. <u>How the facility will identify other residents potentially affected by the same alleged deficient practice:</u> No other residents were immediately affected by this deficient practice. The Maintenance Supervisor designee will conduct a 30 second monthly and a yearly 90 minute test on all battery powered emergency lights. 3. <u>What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur:</u> The Maintenance Supervisor will add to his facility rounds checklist to ensure that all battery powered emergency lighting have the proper testing completed each month. 4. <u>How corrective actions will be monitored to ensure the alleged deficient practice will not recur:</u> The maintenance Supervisor or designee will follow the above audits for three months and</p>	04/10/2012			

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	battery powered emergency lighting fixture. The maintenance supervisor confirmed at the time of record review, 1 1/2 hour tests had not been done .  3.1-19(b)		provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase / decrease the number of audits and frequency of audits.		

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K0048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>1. Based on record review and interview the facility failed to include the use of all types of fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <p>(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> <p>This deficient practice affects any residents, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on review of the facility's General Fire Procedures on</p>	K0048	<p>1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u> The facility's policy and procedure located in Chapter 4: Life Safety Management Plan in the Environment of Care Manual titled Fire Extinguishers revised 11/23/11 does address Class ABC and K fire extinguishers. However, on 3-29-12, the Executive Director contacted Russel Phillips, the company who writes Life Care Centers of America police and procedures for Fire Safety. They were directed to revise the policy to include Class A, Class B, Class C, and Class K fire extinguishers.</p> <p>2. <u>How the facility will identify other residents potentially affected by the same alleged deficient practice:</u> Staff members from all departments were in-serviced by the Executive Director on 3/29/2012 in regards to Single Station Smoke Detectors. Staff will be in-serviced on the new policy and procedure for all types of fire extinguishers once revised policy is received. Policy is to be revised prior to 4/10/12. . 3. <u>What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur:</u></p>	04/10/2012	

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	<p>03/12/12 at 12:50 p.m. with the maintenance supervisor, the plan did not include the use of the ABC fire extinguishers and K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The maintenance supervisor acknowledged at the time of record review, the fire extinguishers had not been included as part of the written plan.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview the facility failed to ensure staff were familiar with fire safety warning devices and their responsibilities related to their alarms. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's General Fire Procedures on 03/12/12 at 12:50 p.m. with the maintenance supervisor, the plan included in section II Response To Alarm, INCLUDING SINGLE STATION SMOKE DETECTORS OR</p>		<p>The Maintenance Supervisor will add to his facility Fire Drill checklist to include inservicing staff on the single station smoke detector procedures. 4. <u>How corrective actions will be monitored to ensure the alleged deficient practice will not recur:</u> The Executive Director or designee will audit the Fire Drills to verify that single station smoke detectors have been discussed with staff members as well as the ABC and K fire extinguishers. She will audit monthly for three months The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase / decrease the number of audits and frequency of audits. _</p>	

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	<p>HEARING "CODE RED" BEING CALLED OUT, staff in the immediate area would activate the fire alarm and begin their emergency response, however, when asked, the maintenance supervisor could not identify what a single station smoke detector was and what the alarm would sound like. At 12:55 p.m. on 03/12/12, CNA # 1 was interviewed to determine her knowledge of the response to single station smoke detectors. She said she had been on staff for six years. She could not identify what a single station smoke detector was, did not know what the alarm would sound like, didn't know these were located in every resident room and denied having any training for a special response to their activation. At 4:45 p.m. on 03/12/12 the Human Resources director, identified as responsible for emergency response training, was interviewed with the maintenance supervisor. She could not identify what a single station smoke detector was, had not heard the alarm in house, and did not know these devices would not activate the fire alarm</p>				

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	system independently.  3.9-19(b)				

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K0051 SS=F	<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>1. Based on observation and interview, the facility failed to provide annunciation for 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all occupants.</p> <p>Findings include:</p>	K0051	<p>1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u></p> <p>On 3-29-12, Alert Alarm came to the facility to assess how they would install a second Fire annunciation panel at the North Nursing station. The work will be completed by 4/11/2012. The Maintenance Supervisor removed the coat /hat rack that was blocking the pull station.</p> <p>2. <u>How the facility will identify other residents potentially affected by the same alleged deficient practice:</u></p> <p>No other residents were immediately affected by this deficient practice</p>	04/10/2012			

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	<p>Based on observation with the maintenance supervisor on 03/12/12 at 5:05 p.m., the main fire alarm control panel was located in an electrical room on the service corridor. A second annunciator panel was located in the entry way adjacent to the executive director's office. The maintenance supervisor confirmed at the time of observations, these areas were not occupied at all hours of the day. There were usually four staff on duty over night assigned to units at opposite ends of the building. The maintenance supervisor said at the time of observations, it could not be assured the staff on duty over night could hear a trouble alarm annunciated on either panel.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 10 manual fire alarm boxes were unobstructed and readily accessible. NFPA 72, National Fire Alarm Code, 2-8.2.1 states manual fire alarm boxes shall be distributed throughout</p>		<p>3. <u>What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur:</u></p> <p>The Maintenance Supervisor will add to his weekly facility rounds checklist the monitoring of all pull stations to ensure that they are not blocked and observe the new annunciation panel.</p> <p>4. <u>How corrective actions will be monitored to ensure the alleged deficient practice will not recur:</u></p> <p>The maintenance Supervisor or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase / decrease the number of audits and frequency of audits.</p>		

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	<p>the protected area so they are unobstructed, readily accessible, and located in the path of exit from the area. This deficient practice could affect all visitors, staff and residents.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 03/12/12 at 4:45 p.m., the manual fire alarm box in the normal path of exit near the main entry was obstructed by an coat/hat rack placed in front of the pull station. The maintenance supervisor acknowledged at the time of observation, the coat/hat rack could interfere with accessibility to the pull station.</p> <p>3.1-19(b)</p>				

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K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 complete sprinkler coverage for all areas in 1 of 4 smoke compartments. LSC 19.1.6.2 requires facilities of Type V (111) construction be provided with complete sprinkler protection. This deficient practice affects visitors, staff, and 10 residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 03/12/12 at 4:06 p.m., one closet in the physical therapy/activities room was not provided with</p>	K0056	<p>1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u></p> <p>-</p> <p>On 3-30-12, S and K Sprinkler Company installed a sprinkler head in the Activity/Therapy closet.</p> <p>2. <u>How the facility will identify other residents potentially affected by the same alleged deficient practice:</u></p> <p>-</p> <p>The Maintenance Supervisor designee will conduct a facility wide audit to ensure that all areas are covered by the automatic sprinkler system.</p> <p>3. <u>What measures were put into place or systematic changes made to ensure that the alleged deficient</u></p>	04/10/2012

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	sprinkler protection The maintenance supervisor acknowledged at the time of observation, there was no sprinkler head in the closet.  3.1-19(b)		<u>practice does not recur:</u>  -  The Maintenance Supervisor will add to his facility rounds checklist to ensure that the entire building is covered by the automatic sprinkler system.  4. <u>How corrective actions will be monitored to ensure the alleged deficient practice will not recur:</u>  The maintenance Supervisor or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase / decrease the number of audits and frequency of audits.  -		

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K0062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 4 smoke compartments were free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Installation of Sprinkler Systems, in 4-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice affects visitors, staff and 10 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 03/12/12 between 12:15 p.m. and 4:45 p.m., sprinkler head obstructions were noted in the physical therapy office where the sprinkler was blocked by the it's</p>	K0062	<p>1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u> _ On 3-26-12, the Maintenance director moved the light fixture in the therapy office. On 3-30-12, K&amp;S Sprinkler Company replaced the two sprinkler heads in the north and south nursing station to a sidewall sprinkler head style. On 3-23-12, The Dietary Supervisor removed the boxes which were blocking both sprinkler heads in the walk in refrigerator/freezer</p> <p>2. <u>How the facility will identify other residents potentially affected by the same alleged deficient practice:</u> _ Maintenance director inspected all areas of the building and found no other sprinkler head obstructions were noted nor were any sprinkler heads found that were closer than 4" from the wall. No other residents were immediately affected by this deficient practice</p> <p>3. <u>What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur:</u> _ The Maintenance Supervisor will add to his facility checklist to check all sprinkler heads are not blocked.</p> <p>4. <u>How corrective actions will be</u></p>	04/10/2012			

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	<p>location one inch from the wall and overhead light fixture. The maintenance supervisor acknowledged marks left on the ceiling indicated a light fixture had been moved or installed after the sprinkler was. In addition, sprinkler heads in the walk in cooler and freezer each had storage located on shelves immediately in front of the sprinkler heads located there. The storage had to be moved to identify the presence of sprinkler heads in the areas.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure sprinkler heads in 2 of 4 smoke compartments had a minimum separation of four inches from a wall. NFPA 25, 4-7.3.3 requires sprinklers shall be located a minimum of four inches from a wall. This deficient practice could affect staff, visitors and 67 residents on the North and South Halls.</p> <p>Findings include:</p>		<p><u>monitored to ensure the alleged deficient practice will not recur:</u> The maintenance Supervisor or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase / decrease the number of audits and frequency of audits.</p>		

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	<p>Based on observation with the maintenance supervisor on 03/12/12 between 12:15 and 4:45 p.m., a single sprinkler head provided protection for the chart rooms behind the north and south nurses stations and the south electrical room. The sprinklers were located one inch from the wall. The distance was confirmed by the maintenance supervisor at the time of observations to be less than the minimum of four inches.</p> <p>3.1-19(b)</p>				

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K0064 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the activities/therapy room was readily accessible. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.3 requires extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. This deficient practice affects visitors, staff, and 12 residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 03/12/12 at 4:05 p.m., the portable fire extinguisher in the physical therapy/activities room was located near the doorway behind two utility carts laden with activity supplies. The maintenance supervisor acknowledged at the time of</p>	K0064	<p>1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u> On 3-22-12, The Maintenance Supervisor moved the fire extinguisher from the therapy room to the hallway outside of the therapy room. 2. <u>How the facility will identify other residents potentially affected by the same alleged deficient practice:</u> The Maintenance Supervisor inspected all other fire extinguishers to verify they were immediately accessible. No other residents were immediately affected by this deficient practice 3. <u>What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur:</u> _ The Maintenance Supervisor will add to his weekly facility rounds checklist the monitoring of all fire extinguishers to ensure that they are not blocked. 4. <u>How corrective actions will be monitored to ensure the alleged deficient practice will not recur:</u> The maintenance Supervisor or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings.</p>	04/10/2012			

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	<p>observation, the fire extinguisher was not immediately accessible.</p> <p>3.1-19(b)</p>		<p>Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase / decrease the number of audits and frequency of audits.</p>		

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K0074 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics 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 observation and interview, the facility failed to ensure window curtains in 1 of 4 smoke compartments were rendered flame resistant. LSC 19.7.5.1 requires draperies and other loosely hanging fabrics to be in accordance with 10.3.1. LSC 10.3.1 requires draperies, curtains, and other similar loosely hanging furnishings and decorations to have flame resistance as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of</p>	K0074	<p>1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u> _ The file for the fire spread information on the curtain in the assisted dining room is kept in the Executive Director's office and the curtain does meet the standard. The sheer curtain on the activities storage room door was removed</p> <p>2. <u>How the facility will identify other residents potentially affected by the same alleged deficient practice:</u> _ No other residents were immediately affected by this deficient practice</p> <p>3. <u>What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur:</u> _ The Maintenance Supervisor</p>	04/10/2012			

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	<p>Textiles and Films. This deficient practice affects visitors, staff and 10 residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 03/12/12 between 2:30 and 4:00 p.m., flame resistance labeling was not found on the assisted dining room window valance or the sheer curtain hanging over the door window to the activities storage room. The maintenance supervisor said at the time of observation, he had no evidence the materials were treated to render them flame resistant.</p> <p>3.1-19(b)</p>		<p>will add to his facility rounds checklist to ensure that the window coverings have the proper flame rating documented and is aware of where the information is maintained in the Executive Director's office. 4. <u>How corrective actions will be monitored to ensure the alleged deficient practice will not recur:</u> The maintenance Supervisor or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase / decrease the number of audits and frequency of audits.</p>		

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K0076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 7 of 9 cylinders of nonflammable gases in resident rooms were properly stored, chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect visitors, staff and 27 residents on the South Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 03/12/12 at 4:00 p.m., seven</p>	K0076	<p>1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u> _ On 3-22-12, Future Medical (oxygen supply company) removed all the oxygen cylinders which were not stored properly from our oxygen storage room. 2. <u>How the facility will identify other residents potentially affected by the same alleged deficient practice:</u> _ No other residents were immediately affected by this deficient practice 3. <u>What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur:</u> _ Staff members from all departments were in-serviced by the Executive Director on 3/29/2012 in regards to proper storage of oxygen tanks. The Maintenance Supervisor will add to his weekly facility checklist to monitor the oxygen storage room to ensure that the tanks are properly stored. 4. <u>How corrective actions will be</u></p>	04/10/2012	

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	<p>oxygen e-cylinders were stored without support in the oxygen supply storage room with five liquid oxygen containers. Two cylinders lay on their sides and five cylinders stood unsupported in a group between a bath tub and liquid oxygen storage tank. The maintenance supervisor acknowledged at the time of observation, the cylinders were not supported properly.</p> <p>3.1-19(b)</p>		<p><u>monitored to ensure the alleged deficient practice will not recur:</u> The maintenance Supervisor or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase / decrease the number of audits and frequency of audits.</p>		

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K0143 SS=E	<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 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 1 of 1 rooms where liquid oxygen transferring takes place was provided with continuous mechanical ventilation to the outside and separation from resident care areas. This deficient practice affects visitors, staff and 27 residents on the South Hall.</p> <p>Findings include:</p> <p>On 03/12/12 at 4:00 p.m., a room on the South Hall identified as a bathroom by a sign on the door was also identified by the maintenance supervisor as the oxygen transfer and storage room.</p>	K0143	<p>1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u> _ On 3-27-12, The Maintenance Supervisor installed a new mechanical exhaust fan and vented it through the roof in the room that houses the oxygen. The toilet, sink, and the bathtub were disconnected and toilet and sink were removed, bathtub will be removed by 4/11/2012. The residents will not be exposed to the oxygen.</p> <p>2. <u>How the facility will identify other residents potentially affected by the same alleged deficient practice:</u> _ No other residents were immediately affected by this deficient practice</p> <p>3. <u>What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur:</u> _ The Maintenance Supervisor</p>	04/10/2012

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	<p>A toilet, sink and bath tub were located in the room with supplies for using the equipment. Nine oxygen e-cylinders and five 181 L capacity liquid oxygen supply tanks were stored between the bathtub and an open window. A mechanical vent was not running and the maintenance supervisor said he did not think there was mechanical ventilation for the room. A vent was observed in the ceiling but the maintenance supervisor said he thought it was the bathroom vent which did not go directly to the outside and did not appear to be working. A blank face plate was located on the wall adjacent to the door where a switch might have been. Staff # 1 was coming in and out of the room at the time of observation and said the room was in use as a toilet facility for residents. The maintenance supervisor acknowledged at the time of observation, there was no continuous mechanical ventilation and the space could expose residents to the oxygen storage and transfilling.</p> <p>3.1-19(b)</p>		<p>will add to his weekly facility rounds checklist to check the operation of the oxygen room exhaust fan. 4. <u>How corrective actions will be monitored to ensure the alleged deficient practice will not recur:</u> The maintenance Supervisor or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase / decrease the number of audits and frequency of audits.</p>		

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K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation of the emergency generator equipment with the maintenance director on 03/12/12 at 3:35 p.m., a remote emergency shut off device was not</p>	K0144	<p>1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u> _ On 3-30-12, Alternative Energy came out to assess installing an E-Stop button on the generator. They will also disconnect the silent button on the annunciator panel to ensure that staff cannot silence the panel. Work will be completed by 4/11/2012. 2. <u>How the facility will identify other residents potentially affected by the same alleged deficient practice:</u> _ No other residents were immediately affected by this deficient practice 3. <u>What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur:</u> _ The Maintenance Supervisor will add to his facility weekly rounds checklist to ensure that the generator annunciator panel is free from any and all papers that might block the panel. 4. <u>How corrective actions will be monitored to ensure the alleged deficient practice will not recur:</u> The maintenance Supervisor or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director</p>	04/10/2012

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	<p>found. The maintenance supervisor said at the time of observation, there was no remote emergency shut off for the generator.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciator panels was maintained. NFPA 99, 3-5.4.1.1(a) equipment associated with the generator set, such as the annunciator panel shall be maintained. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 03/12/12 at 4:30 p.m., the audible trouble alarm on the generator annunciator panel located at the north nurses station had been silenced. The trouble light was not visible due to papers hanging over the equipment. When reset, the annunciator alarmed. LPN# 1 said at the time of observation, the alarm had</p>		<p>will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase / decrease the number of audits and frequency of audits.</p>		

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	<p>sounded "this afternoon" and "we didn't know what it was" and it was silenced. She said the alarm was not reported to maintenance staff. The maintenance director checked the emergency generator immediately and discovered the generator had not been put back on line after testing earlier. He acknowledged he might not have done it if the issue of the annunciator alarm had not been discovered. He said he assumed staff knew to alert maintenance for any trouble.</p> <p>3.1-19(b)</p>				

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K0147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA 70 National Electrical Code, 1999 Edition, 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 2 residents in room 214.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 03/12/12 at 4:15 p.m. a power strip extension cord was used to supply electricity for the nebulizer in room 214. The maintenance supervisor said at the time of observation, he was unaware the cord was in use.</p> <p>3.1-19(b)</p>	K0147	<p>1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u> _ On 3-19-12, The Maintenance Supervisor removed the power strip extension cord from room 214. 2. <u>How the facility will identify other residents potentially affected by the same alleged deficient practice:</u> _ All resident rooms were checked for power strip extension cords No other residents were immediately affected by this deficient practice 3. <u>What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur:</u> _ Staff members from all departments were in-serviced by the Executive Director on 3/29/2012 in regards to use of power strips in the building. The Maintenance supervisor will add to his weekly facility checklist to check the resident rooms for the use of power strip extension cords and remove them when found. 4. <u>How corrective actions will be monitored to ensure the alleged deficient practice will not recur:</u> The maintenance Supervisor or designee will follow the above audits for three months and provide the Executive Director with the results of those audits</p>	04/10/2012	

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			monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase / decrease the number of audits and frequency of audits.	