

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/08/2016
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NAME OF PROVIDER OR SUPPLIER  LYNHURST HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241
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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: 09/08/16</p> <p>Facility Number: 000385 Provider Number: 15E667 AIM Number: 100291340</p> <p>At this Life Safety Code survey, Lynhurst Healthcare was found not in compliance with Requirements for Participation in 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 facility, constructed in two sections is fully sprinklered. The oldest section, a former two story private residence with a basement and the newer section, a one story addition were both determined to be of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. The facility has battery operated smoke detectors</p>	K 0000	<p>K0000Preparation and execution of this plan of correction does not constitute an admission to or an agreement by the provider with the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state laws. Lynhurst Healthcare maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Lynhurst Healthcare asserts that it is and was in substantial compliance with regulations governing the operation of long term care facilities and the Plan of Correction in its entirety, constitutes this provider's allegation of compliance. Completion dates are provided for procedural processing purposes to comply with federal and state regulations and to correlate with the most recent contemplated or accomplished corrective action(s). These do not necessarily chronologically correspond to the date that Lynhurst Healthcare is under the</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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	<p>facility failed to ensure 1 of over 19 corridor doors to resident rooms were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 10 residents, staff and visitors in the vicinity of Room 5.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Manager during a tour of the facility from 10:40 a.m. to 12:15 p.m. on 09/08/16, the corridor door to Room 5 failed to latch into the door frame because the latching mechanism did not protrude into the latching plate. In addition, a one half inch in diameter hole was noted near the middle of the door which would not resist the passage of smoke. Based on interview at the time of the observations, the Maintenance Manager acknowledged the aforementioned corridor door had an impediment to closing, latching and would not resist the passage of smoke.</p> <p>3.1-19(b)</p>		<p>accomplished for those residents found to have been affected? Although the potential for any resident to be affected existed, no resident was identified as having been negatively affected by the door latch that had difficulty closing. The door and latch have been replaced. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Although the potential for any resident to be affected existed, no resident was identified as having been negatively affected by the door latch that had difficulty closing. The door and latch have been replaced. The other corridor doors were checked and all are in working order. 3) What measures will be put into place or what systemic changes will be made? The door and latch have been replaced. The other corridor doors were checked and all are in working order. Maintenance will include an audit of all doors in the facility to monthly rounds documentation. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Maintenance will include an audit of all doors in the facility to monthly rounds documentation. 5) By what date the systemic changes will be completed. 10-8-2016</p>		

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K 0025 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. LSC 19.3.7.3 refers to Section 8.3. 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. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p>	K 0025	<p>KO025 1) What action(s) will be accomplished for those residents found to have been affected? Although the potential for any resident to be affected existed, no resident was identified as having been negatively affected by the (A) The opening in the Dietary Office, (B) the opening under the dish washing machine. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Although the potential for any resident to be affected existed, no resident was identified as having been affected by the (A) The opening in the Dietary Office, (B) the opening under the dish washing machine. 3) What measures will be put into place or what systemic changes will be made? Both areas of concern were repaired with fire resistant material. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Maintenance is aware that openings must be sealed with fire</p>	10/08/2016

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K 0050 SS=F	<p>Based on observation with the Maintenance Manager during a tour of the facility from 10:40 a.m. to 12:15 p.m. on 09/08/16, the following was noted in the ceiling smoke barrier:</p> <p>a. a two foot by four inch opening in the ceiling of the Dietician's Office for the passage of fifteen electrical conduits from the electrical panels on the emergency generator was not firestopped.</p> <p>b. the two inch annular space surrounding a one inch in diameter pipe which penetrated the ceiling of the kitchen by the dishwashing machine was not firestopped.</p> <p>Based on interview at the time of observation, the Maintenance Manager acknowledged the aforementioned holes in the ceiling smoke barrier did not maintain at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		<p>resistant/retardant material. Areas will be added to the monthly audits/documentation for the maintenance manager. 5) By what date the systemic changes will be completed. 10-8-2016</p>		

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Bldg. 01	<p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>1. Based on record review and interview, the facility failed to document fire drills conducted on the first shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Lynhurst Healthcare Fire Drill Report" documentation with the Maintenance Manager during record review from 9:05 a.m. to 10:40 a.m. on 09/08/16, documentation of a fire drill conducted on the first shift in the second quarter (April, May, June) 2016 was not available for review. Based on interview at the time of record review, the Maintenance Manager stated additional fire drill documentation not was available for review and acknowledged documentation of a fire drill conducted on the first shift in the second quarter</p>	K 0050	K0050 1) What action(s) will be accomplished for those residents found to have been affected? Although the potential for any resident to be affected existed, no resident was identified as having been negatively affected. Fire drills are accomplished as mandated and this documentation was located after the Fire Marshall had exited the facility. The Maintenance Manager, who is responsible for the drills and the proper documentation for such will be counseled on failure to activate the fire alarm system during one of numerous drills. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Although the potential for any resident to be affected existed, no resident was identified as having been affected. Fire drills are accomplished as mandated and this documentation was located after	10/08/2016			

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	<p>2016 was not available for review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to document activation of the fire alarm system for fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Lynhurst Healthcare Fire Drill Report" documentation with the Maintenance Manager during record review from 9:05 a.m. to 10:40 a.m. on 09/08/16, documentation for the second shift fire drill conducted in January 2016 at 3:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal. Documentation for the aforementioned second shift fire drill</p>		<p>the Fire Marshall had exited the facility. (Documentation had slid off the wall hook and was located under the maintenance desk.) The Maintenance Manager, who is responsible for the drills and the proper documentation for such will be counseled on failure to activate the fire alarm system during one of numerous drills. 3) What measures will be put into place or what systemic changes will be made? Fire drills are accomplished as mandated and this documentation was located after the Fire Marshall had exited the facility. Fire drills will continue as per State and Federal Regulations. (Documentation had slid off the wall hook and was located under the maintenance desk.) The Maintenance Manager, who is responsible for the drills and the proper documentation for such will be counseled on failure to activate the fire alarm system during one of numerous drills. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Fire drills are accomplished as mandated and this documentation was located after the Fire Marshall had exited the facility. The Maintenance Manager, who is responsible for the drills and the proper documentation for such will be counseled on failure to activate the fire alarm system during one</p>	

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	<p>stated "Alarm company received signal at 9:00 p.m." Based on interview at the time of record review, the Maintenance Manager acknowledged documentation for the aforementioned second shift fire drill conducted after 6:00 a.m. but before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal at the time of the fire drill.</p> <p>3.1-19(b) 3.1-51(ac)</p> <p>3. Based on record review and interview, the facility failed to document quarterly fire drills on the second shift for 1 of 4 quarters and the third shift for 3 of 4 quarters. LSC 19.7.1.2 requires ambulatory health care facilities to conduct quarterly fire drills for each shift and fire drills shall include the transmission of the fire alarm signal. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Lynhurst Healthcare Fire Drill Report" documentation with the Maintenance Manager during record review from 9:05 a.m. to 10:40 a.m. on 09/08/16, documentation for the second shift (3:00 p.m. to 11:00 p.m.) fire drill</p>		<p>of numerous drills. Fire drills will continue as per State and Federal Regulations and the Maintenance Manager will monitor and document that such has taken place. 5) By what date the systemic changes will be completed. 10-8-2016</p>				

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K 0052 SS=F Bldg. 01	<p>conducted in January 2016 did not include the calendar day of the drill. In addition, documentation for third shift (11:00 p.m. to 7:00 a.m.) fire drills in November 2015, February 2016 and May 2016 each did not include the calendar day of the drill. Based on interview at the time of record review, the Maintenance Manager acknowledged documentation for the aforementioned fire drills was incomplete because it did not include the calendar day of the drill.</p> <p>3.1-19(b) 3.1-51(ac)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance</p>	K 0052	K0052 1) What action(s) will be accomplished for those residents found to have been affected? Although the potential for any resident to be affected existed, no resident was identified as having been affected. 2) How the facility will identify other	10/08/2016	

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	<p>with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm initiating devices, alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Superior System &amp; Supply's "Periodic Fire Alarm Inspection and Testing Report" documentation dated 12/31/15 and 06/27/16 with the Maintenance Manager during record review from 9:05 a.m. to 10:40 a.m. on 09/08/16, ten smoke detectors were functionally tested. Review of Superior System &amp; Supply's "Smoke Detector Sensitivity Test for Lynhurst Health Care" dated 12/04/14 and "Fire Alarm Inspection Report" dated 06/29/15, indicated a total of thirteen smoke detectors were tested in the facility. Based on interview at the time of record review, the Maintenance Manager stated no smoke detectors have been removed from the facility in the last two years and acknowledged not all facility fire alarm system smoke detectors had been functionally tested in the most recent twelve month period.</p>		<p>residents having the potential to be affected and what corrective action will be taken? Although the potential for any resident to be affected existed, no resident was identified as having been affected. Superior System will be notified of the issue and the Maintenance Manager of the facility will accompany Superior Systems during all inspections in order to ensure all smoke detectors are made available to Superior Systems. This action will be documented. 3) What measures will be put into place or what systemic changes will be made? Superior System will be notified of the issue and the Maintenance Manager of the facility will accompany Superior Systems during all inspections in order to ensure all smoke detectors are made available to Superior Systems. This action will be documented. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Superior System will be notified of the issue and the Maintenance Manager of the facility will accompany Superior Systems during all inspections in order to ensure all smoke detectors are made available to Superior Systems. This action will be documented. The Maintenance Manager will be in charge of said documentation and monitoring the contractors. 5) By what date</p>	

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K 0062 SS=C Bldg. 01	<p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. LSC 9.7.1 states all automatic sprinkler systems shall be maintained in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 states sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Manager during a tour of the facility from 10:40 a.m. to 12:15 p.m. on 09/08/16, the following was noted:</p> <p>a. electrical wiring was wrapped around a one foot section of sprinkler pipe in the kitchen near the corridor door.</p> <p>b. an electrical cable was affixed to a five</p>	K 0062	<p>the systemic changes will be completed. 10-8-2016</p> <p>K0062 1) What action(s) will be accomplished for those residents found to have been affected? Although the potential for any resident to be affected existed, no resident was identified as having been affected. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Although the potential for any resident to be affected existed, no resident was identified as having been affected. The wiring in question had caused no ill effect however the wiring has been fixed. 3) What measures will be put into place or what systemic changes will be made? Wiring has been fixed. During monthly rounds the Maintenance Manager will add audits of wiring to his documentation. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? During monthly rounds the Maintenance Manager will add audits of wiring to his documentation. 5) By what date</p>	10/08/2016			

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K 0069 SS=D Bldg. 01	<p>foot length of sprinkler pipe in the Mechanical Room by the Dining Room. Based on interview at the time of observation, the Maintenance Manager acknowledged the aforementioned sprinkler pipe locations were being used to support nonsystem components.</p> <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 1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA</p>	K 0069	<p>the systemic changes will be completed. 10-8-2016</p> <p>K0069 1) What action(s) will be accomplished for those residents found to have been affected? Although the potential for any resident to be affected existed, no resident was identified as having been affected. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Although the potential for any resident to be affected existed, no resident was identified as having been affected. Koorsen has been notified and is scheduled to come to the facility for range hood inspection/cleaning, on 9-20-16. Range hood baffles have been</p>	10/08/2016

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	<p>96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect three staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on review of Koorsen Environmental Services "Kitchen Exhaust Cleaning Work Order" documentation dated 08/10/15 and 02/25/16 with the Maintenance Manager during record review from 9:05 a.m. to 10:40 a.m. on 09/08/16, documentation of kitchen exhaust system inspection six months after 02/25/16 was not available for review. Based on observation with the Maintenance Manager during a tour of the facility from 10:40 a.m. to 12:15 p.m. on 09/08/16, Koorsen Environmental Services had affixed a sticker to the range hood indicating the</p>		<p>adjusted to meet NFPA requirements. 3) What measures will be put into place or what systemic changes will be made? Koorsen has been notified and is scheduled to come to the facility for range hood inspection/cleaning, on 9-20-16. Koorsen will be notified that any changes to the schedule of their inspections must be approved by the Executive Director of Lynhurst Healthcare. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Koorsen has been notified and is scheduled to come to the facility for range hood inspection/cleaning, on 9-20-16. Koorsen will be notified that any changes to the schedule of their inspections must be approved by the Executive Director of Lynhurst Healthcare. Range hood baffles have been adjusted to meet NFPA requirements. 5) By what date the systemic changes will be completed. 10-8-2016</p>	

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	<p>next scheduled inspection was due in August 2016 following the 02/25/16 inspection. Based on interview at the time of record review and of the observation, the Maintenance Manager acknowledged documentation of semiannual kitchen exhaust system inspection six months after 02/25/16 was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 3 of 3 kitchen exhaust system baffles were installed correctly. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 3-2.5 states filters shall be installed at an angle not less than 45 degrees from the horizontal. This deficient practice could affect three staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Manager during a tour of the facility from 10:40 a.m. to 12:15 p.m. on 09/08/16, three of three baffles in the kitchen range hood are aligned horizontally in the kitchen range hood exhaust system. Based on interview at the time of observation, the Maintenance</p>			

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K 0130 SS=C Bldg. 01	<p>Manager acknowledged the baffles in the kitchen range exhaust hood were aligned horizontally.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 19 of 19 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Smoke Detector Maintenance Log for 2015/2106" with the Maintenance Manager during record review from 9:05 a.m. to 10:40 a.m. on 09/08/16, documentation of resident sleeping room battery operated smoke detector testing and cleaning for June, July and August 2016 was not available for review. Based on observations with the Maintenance</p>	K 0130	<p>K0130 1) What action(s) will be accomplished for those residents found to have been affected? Although the potential for any resident to be affected existed, no resident was identified as having been affected. Documentation was located in the book given to the surveyor but the pages were sticking together in the book. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Although the potential for any resident to be affected existed, no resident was identified as having been affected. Documentation was located in the book given to the surveyor but the pages were sticking together in the book. Documentation in question is attached to this POC. 3) What measures will be put into place or what systemic changes will be made? Documentation was located in the book given to the surveyor but the pages were sticking together in the book. Documentation in question is</p>	10/08/2016

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K 0144 SS=C Bldg. 01	<p>Manager during a tour of the facility from 10:40 a.m. to 12:15 p.m. on 09/08/16, battery operated smoke detectors were installed in each of 19 resident sleeping rooms in the facility. Based on interview at the time of record review and of the observations, the Maintenance Manager stated the battery operated smoke detectors require monthly testing and cleaning and acknowledged documentation of resident sleeping room battery operated smoke detector testing and cleaning after May 2016 was not available for review.</p> <p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>1. Based on observation and interview, the facility failed to provide adequate emergency task lighting in and around the generator set in accordance with NFPA 101, 2000 Edition, Life Safety Code. Section 19.2.9.1 states emergency lighting shall be provided in accordance with Section 7.9. LSC Section 7.9.2.3 requires emergency generators providing power to emergency lighting systems</p>	K 0144	<p>attached to this POC. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? Documentation was located in the book given to the surveyor but the pages were sticking together in the book. Documentation in question is attached to this POC. 5) By what date the systemic changes will be completed. 10-8-2016</p> <p>K0144 1) What action(s) will be accomplished for those residents found to have been affected? Although the potential for any resident to be affected existed, no resident was identified as having been affected. The facility maintains the emergency generator according to NFAP, State and Federal regulations/guidelines. 2) How the facility will identify other</p>	10/08/2016

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	<p>shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires the EPS (Emergency Power Supply) equipment location shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Manager during a tour of the facility from 10:40 a.m. to 12:15 p.m. on 09/08/16, the battery operated emergency light located at the emergency generator location failed to illuminate when its respective test button was pressed five times. Based on interview at the time of observation, the Maintenance Manager acknowledged the aforementioned battery operated emergency light failed to illuminate.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure documentation of the reliability for the off site fuel source for 1 of 1 emergency generators was available for review. NFPA 110 1999 Edition, Standard for</p>		<p>residents having the potential to be affected and what corrective action will be taken? Although the potential for any resident to be affected existed, no resident was identified as having been negatively affected. The facility maintains the emergency generator according to NFAP, State and Federal regulations/guidelines. The light for the emergency generator was tested on 8-31-2016 and had gone out by 9-8-2016 ( seven days later). 3) What measures will be put into place or what systemic changes will be made? The light for the emergency generator was tested on 8-31-2016 and had gone out by 9-8-2016 ( seven days later). Please see attached. Maintenance will audit the outside light for the generator. Citizen's Gas provides the fuel for the facility's emergency generator. As of 9-19-16 they have been contacted to provide a "letter of reliability" for their fuel services to our building. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? The testing for the light on the facility's emergency generator will be accomplished on a weekly basis and documented. Maintenance Manager will be responsible for this testing and documentation. Citizen's Gas provides the fuel for the facility's emergency</p>	

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	<p>Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <ul style="list-style-type: none"> <li>a) Liquid Petroleum products at atmospheric pressure</li> <li>b) Liquefied petroleum gas (liquid or vapor withdrawal)</li> <li>c) Natural or synthetic gas</li> </ul> <p>Exception: For Level 1 installations in locations where the probability of interruption of offsite fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all clients, staff and visitors. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:</p> <ul style="list-style-type: none"> <li>1. A statement of reasonable reliability of the natural gas delivery.</li> <li>2. A brief description that supports the statement regarding the reliability.</li> </ul>		<p>generator. As of 9-19-16 they have been contacted to provide a "letter of reliability" for their fuel services to our building. (mheadquarters@citizensenergygroup.com and phone number 317-924-3311) 5) By what date the systemic changes will be completed. 10-8-2016</p>	

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	<p>3. A statement that there is a low probability of interruption of the natural gas.</p> <p>4. A brief description that supports the statement regarding the low probability of interruption,</p> <p>5. The signature of a technical person from the natural gas provider.</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Manager from 9:05 a.m. to 10:40 a.m. on 09/08/16, documentation of reliability from the off site natural gas supplier for the emergency generator was not available for review. Based on observation with the Maintenance Manager during a tour of the facility from 10:40 a.m. to 12:15 p.m. on 09/08/16, the facility emergency generator is fueled by natural gas only. Based on interview at the time of record review and observation, the Maintenance Manager stated the fuel source for the emergency generator was natural gas and acknowledged documentation of reliability from the natural gas provider was not available for review.</p> <p>3.1-19(b)</p>			

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K 0147 SS=E Bldg. 01	<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 1 of 1 extension cords including power strips and non-fused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 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 could affect 10 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Manager during a tour of the facility from 10:40 a.m. to 12:15 p.m. on 09/08/16, a three receptacle multiplug adaptor was plugged into an electrical wall outlet next to the fire alarm panel at the nurse's station. Based on interview at the time of observation, the Maintenance Manager stated the time clock and</p>	K 0147	<p>K0147 1) What action(s) will be accomplished for those residents found to have been affected? Although the potential for any resident to be affected existed, no resident was identified as having been affected. 2) How the facility will identify other residents having the potential to be affected and what corrective action will be taken? Although the potential for any resident to be affected existed, no resident was identified as having been negatively affected. 3) What measures will be put into place or what systemic changes will be made? IT company has been notified as of 9-19-2016 that the multi-plug adapter must be removed. 4) How the corrective actions will be monitored and what quality assurance program will be put into place; who will monitor? IT company has been notified as of 9-19-2016 that the multi-plug adapter must be removed. Maintenance Manager will add an audit of electrical outlets to his monthly maintenance logs. 5) By what date the systemic changes will be completed. 10-8-2016</p>	10/08/2016

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	Internet service for the building were plugged into the adaptor and acknowledged a multiplug adaptor was being used as a substitute for fixed wiring in the aforementioned location.  3.1-19(b)				