

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155666	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/28/2016
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NAME OF PROVIDER OR SUPPLIER AUBURN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN 46706
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/28/16</p> <p>Facility Number: 000307 Provider Number: 155666 AIM Number: 100285660</p> <p>At this Life Safety Code survey, Auburn Village 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 sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, areas open to the corridors and in resident rooms. The facility has a capacity of 79 and had a census of 37 at the time of this survey.</p>	K 0000	<p>This plan of correction is prepared and executed because the state and federal law require it. This plan of correction shall not be deemed an admission to or agreement with the state allegations. Auburn Village maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Auburn Village further maintains that the allegations set forth herein do not substantiate or constitute substandard quality of care. Please accept the last date noted on the plan of correction as the facility's credible allegation of compliance. Auburn Village requests paper compliance for K018, K022, K025, K029, K038, K045, K066, K144, K145. There was no actual citation of harm to any of the residents.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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K 0018 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinklered.</p> <p>Quality Review completed on 05/04/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure there were no impediments to the closing of 1 of 1 medical office doors protecting corridor openings. This deficient practice could affect 15 residents in one of four smoke compartments.</p> <p>Findings include:</p>	K 0018	<p>K018 NFPA 101 Life Safety Code Standard</p> <p>All door wedges have been removed</p> <p>- All residents have the potential to be effected; however there was no actual harm to none.</p> <p>- Wedges were removed and</p>	05/13/2016

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K 0022 SS=E Bldg. 01	<p>Based on observation during a tour of the facility with the Maintenance Director on 04/28/16 at 1:04 p.m., the corridor door to the medical office was propped open with a door wedge. Based on interview at the time of observation, this was acknowledged by the Maintenance Director.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1</p> <p>Based on observation and interview, the facility failed to ensure 3 of 4 paths of egress was marked with an approved sign to make the direction of travel to reach the nearest exit apparent. LSC 7.10.1.2 requires exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. This deficient practice affects up to 35 residents using</p>	K 0022	<p>staff was in-serviced on 05/02/16 (see attachment A) On inappropriate door wedges and not propping the doors.</p> <p>- Maintenance personnel or designee will monitor daily times three weeks then three times per week times three weeks then twice a week there after.</p> <p>- Date for completion is 05/13/2016</p> <p>K022 NFPA 101 Life Safety Code Standard</p> <p>All exits have been properly marked</p> <p>- All residents have the potential to be effected; however there was no actual harm to none</p> <p>- All doors have been properly labeled (see attachment of Picture A South hall door, B East Door and C</p>	05/13/2016
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K 0025 SS=E Bldg. 01	<p>the east exit corridor, dining room exit, and court yard exit.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 04/29/16 between at 11:00 a.m., and 2:00 p.m., the following areas had a lack of approved sign to make the direction of travel to reach the nearest exit apparent:</p> <p>a) The corridor outside the main dining room exit by the kitchen that went through a construction area did not have exit signs that would indicate the direction of exit travel.</p> <p>b) The door for the east exit and the corridor outside the east exit that went through a construction area did not have exit signs that would indicate the direction of exit travel.</p> <p>c) The corridor from the east court yard to an exit that went through a construction area did not have exit signs that would indicate the direction of exit travel.</p> <p>Based on interview at the time of observation, the Maintenance Director acknowledged the lack of exit signs.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to</p>		<p>East courtyard door)</p> <p>- Maintenance personnel or designee will monitor door exit signs in place weekly until construction is complete.</p> <p>- Date for completion is 05/13/2016</p>		

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K 0029 SS=E	<p>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 were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 15 residents in one of 1 of 4 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Director on 04/28/15 at 11:51 a.m., in the ceiling of the main electrical room two unsealed one fourth of an inch penetration around wires and an eighth inch crack around a hole where the fire caulk was falling out. Based on interview at the time of observation, the Maintenance Director acknowledge and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 0025	<p>K025 NFPA 101 Life Safety Code Standard</p> <p>Sealed holes with new Fire Caulk on the ceiling in the electrical room</p> <ul style="list-style-type: none"> - All residents have the potential to be effected; however there was no actual harm to none. - Hole was sealed with fire caulk (see attached Picture D Electrical room fire caulk) - Construction crew has been notified to make building aware if thru penetration is being made. Maintenance personnel and Contractor to verify that thru penetration are sealed properly on a daily basis until construction is complete. Maintenance personnel to verify monthly during QA process thereafter. - Date for completion is 05/13/16 	05/13/2016			

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Bldg. 01	<p>One hour fire rated construction (with 0 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>Based on observation and interview, the facility failed to ensure 1 of 1 kitchen doors automatically close and latched into the door frame. This deficient practice could affect 20 residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 04/29/16 at 12:24 p.m., the door going in a form the dining room to the kitchen did not automatically latch into the door frame due to air flow. Based on interview, this was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>	K 0029	<p>K029 NFPA 101 Life Safety Code Standard</p> <p>Kitchen door closer was adjusted</p> <ul style="list-style-type: none"> - All residents have the potential to be effected; however there was no actual harm to none - Kitchen door closer was adjusted by Maintenance Director to make sure door closes and self latches into frame. - Maintenance personnel or designee will monitor three times a week times for three weeks, then two times per week for three weeks, then weekly until construction is complete. - Date of completion is 05/13/2016 	05/13/2016
K 0038 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are</p>			

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	<p>readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure exit access was arranged so 2 of 4 exits were readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1 requires the means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. In addition to providing the required width to allow all occupants safe access to a public way, such access also needs to meet the requirements with respect to maintaining the means of egress free of obstructions that would prevent its use, such as snow and the need for its removal in some climates or soft ground during heavy periods of rain. This deficient practice could affect 28 residents using the dining room and east exits in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 04/28/16 between 12:20 p.m. and 1:30</p>	K 0038	<p>K 038 NFPA 101 Life Safety Code Standard</p> <p>Hard clearable surfaces installed to a public way for both exits (east exit and dinning exit)</p> <ul style="list-style-type: none"> - All residents have the potential to be effected; however there was no actual harm to none. - Hard surfaces installed to provide a clear public exit by contractor on 05/3/2016. (See attached Picture E of East Exit and Picture F of South Exit) - Maintenance personnel or designee will monitor weekly until construction is complete. - Date of completion is 05/13/2016 <p>Sink, Floor Cleaners and Mattress removed from Egress Path</p> <ul style="list-style-type: none"> - All residents have the potential to be effected; however there was no actual harm to none. - Sink, Floor Cleaners and Mattress were removed from Egress path on 04/28/2016 in construction area. Staff in-serviced on maintaining clear Egress on 05/02/2016 (see attachment B) 	05/13/2016

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	<p>p.m., both the east hall exit and the dining room exit discharged into mud due to construction. There were no hard clearable surface that led to a public way for both exits. Based on interview at the time of observation, the Maintenance Director acknowledged the lack of a hard exit path to a public way.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 4 exit access corridors was readily accessible and unobstructed at all times. This deficient practice could affect 19 residents using the east exits in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 04/28/16 at 12:20 p.m., a sink, two floor cleaners, and a mattress were stored in the east hall construction area which was part of the egress path for the east hall. Based on an interview at the time of observation, the Maintenance Director stated the items were stored in the hall because of the lack of storage due to construction.</p> <p>3.1-19(b)</p>		<ul style="list-style-type: none"> - Contractor and Maintenance personnel will monitor daily for clear egress pathways until construction complete. - Date of completion is 05/13/2016 Codes posted on left side of door jam - All residents have the potential to be effected; however there was no actual harm to none. - Maintenance personnel posted security code on left side of door jam and inserviced staff on door opening procedures and code usage of 05/03/2016 (See attached C) Doors were originally placed and secured to prevent resident access to construction areas for their safety. - Maintenance personnel will monitor weekly to ensure codes remain posted until construction is completed. - Date for completion is 05/13/2016 	

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	<p>3. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 4 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 18.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect 19 residents using the east exits in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 04/28/16 at 12:30 p.m., the east exit door, that did not require special security measures, was magnetically locked and could be opened by entering a code, but no code was posted. Based on interview at the time of observation, the Maintenance Director acknowledged the</p>			
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K 0045 SS=E Bldg. 01	<p>lack of the code on the exit door.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8</p> <p>Based on observation and interview, the facility failed to ensure proper egress lighting for 3 of 4 emergency exits. This deficient practice could affect 35 residents.</p> <p>Finding include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Director on 04/28/15 from 11:30 a.m. to 2:01 p.m., the following exit discharges or egress paths lacked proper egress lighting:</p> <p>a) The exit door leading outside form the dining room exit did not have any lighting for the exit.</p> <p>b) The exit door leading outside form the east exit did not have any lighting for the exit.</p> <p>c) There were no lights in the east court yard which was a part of the exit path for the dining room east exit.</p>	K 0045	<p>K045 NFPA 101 Life Safety Code Standard</p> <p>Exit Signs Lighting</p> <ul style="list-style-type: none"> - All residents have the potential to be effected; however there was no actual harm to none. - Exit lighting installed by contractor on 05/03/2016 (See attachment PIC G Dining Room, PIC H East Exit, PIC I East Courtyard). - Maintenance personnel or designee will verify that lights are in working order on Exits and Courtyard until construction is complete. - Date for completion is 05/13/2016 	05/13/2016

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K 0066 SS=E Bldg. 01	<p>Based on interview, this was confirmed by Maintenance Director at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 area where smoking was permitted for staff was maintained. This deficient practice could affect up to 30 residents in the west court yard and when using the west exit.</p> <p>Findings include:</p>	K 0066	<p>K066 NFPA 101 Life Safety Code Standard</p> <p>Cigarette Butts cleaned</p> <p>- All residents have the potential to be effected; however there was no actual harm to none.</p>	05/13/2016

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K 0144 SS=C Bldg. 01	<p>Based on an observation during a tour of the facility with the Maintenance Director on 04/28/16 at 2:20 p.m. and at 2:25 p.m., the two staff designated smoking areas located outside the west exit and in the west court yard was provided with a "smoker ' s oasis" which is a container with a long neck used for cigarette butts. At least 30 cigarette butts were observed on the ground in the courtyard smoking area, and 50 plus cigarette butts were observed on the ground and in the grass of the west exit smoking area. Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</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) 1. Based on observation and interview, the facility failed to provide adequate emergency task lighting in and around 1 of 1 generator sets in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.2.3 requires emergency generators providing power to</p>	K 0144	<p>- Cigarette butts were cleaned up at West side of the building and Courtyard, Staff in-services on cigarette disposal and designated smoking areas (See attachment D)</p> <p>- Maintenance personnel or designee will do daily checks on West side of building and Courtyard daily to ensure that cigarettes are being disposed of properly.</p> <p>- Date for completion is 05/13/2016</p> <p>K144 NFPA 101 Life Safety Code Standard</p> <p>Emergency lighting installed</p> <p>- All residents have the potential to be effected; however</p>	05/13/2016			

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NAME OF PROVIDER OR SUPPLIER AUBURN VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>emergency lighting systems 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 that the EPS (Emergency Power Supply) equipment location shall be provided with battery-powered emergency lighting. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 04/28/16 at 1:00 p.m., the emergency generator enclosed within the court yard lacked a battery-powered emergency light. Based on interview, this was confirmed by Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators ran under load for 30 minutes and was allowed a 5 minute cool down period after a load test. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard</p>		<p>there was no actual harm to none.</p> <ul style="list-style-type: none"> - Emergency lighting with a 90 minute battery installed above generator by contractor on 05/03/2016 (See attached PIC) - Maintenance personnel or designee to check battery life in Emergency lighting Bi-weekly. - Date for completion is 05/13/2016 <p>Generator checklist amended</p> <ul style="list-style-type: none"> - All residents have the potential to be effected; however there was no actual harm to none. - Generator check list amended to include run time and cool down periods. New in depth monthly load check list implemented. - Maintenance personnel or designee to utilize new amended Emergency Generator Log. - Date for completion is 05/13/2016 				

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	<p>for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shut down. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include: Based on review of the facility's Emergency Generator monthly testing log with the Maintenance Director on 04/19/16 at 9:56 a.m., the generator log form documented the generator was tested under load monthly, however, the</p>			

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K 0145 SS=F Bldg. 01	<p>form did not indicate that the generator ran for at least 30 minutes and had a cool down time following its load test. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99)</p> <p>Based on observation and interview, the facility failed to divide a Type 1 Essential Electrical System (EES) servicing 17 of 17 resident on life support in accordance with NFPA 99, 1999 edition, Section 3-4.2.2. This deficient practice could affect all 17 residents on ventilators.</p> <p>Finding include:</p> <p>Based on observations with the Maintenance Director on 04/28/16 during a tour of the facility from 10:30 am to 3:00 pm, the TYPE 1 EES had one transfer switch with one critical branch for the east hall resident room vent unit and another critical branch for the west hall resident room vent units. The life safety branch and the equipment branches</p>	K 0145	<p>K145 NFPA 101 Life Safety Code Standard</p> <p>EES Modifications</p> <ul style="list-style-type: none"> - All residents have the potential to be effected; however there was no actual harm to none. - Quote received to relocate existing feed to panel 03 move from existing panel breaker to ATS, New disconnect for panel 03 100a 3 pole, Relocation of phone system, fire alarm, nurse call, heat and room circuitry. - Henry Electric out of Fort Wayne IN to do the Emergency Power Modifications , see attached quotation signed by Administrator to authorize repairs dated May 13, 	05/20/2016

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	were comingled in the electrical room emergency panel #03. Based on interview, the Maintenance Director acknowledged emergency panel #03 contained life safety branch features such as the fire alarm, exit light and outside lights as well as equipment branch features such as the dietary kitchen, furnaces, hall lighting, medication room and nurses station lights. 3.1-19(b)		2016 - Date of completion projected to be May 20th, 2016		