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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155022 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 09/24/2012 |
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| NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF SHELBYVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE 2309 S MILLER ST SHELBYVILLE, IN 46176 |
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| K0000 | <p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/24/12</p> <p>Facility Number: 000009 Provider Number: 155022 AIM Number: 100274760</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Heritage House of Shelbyville 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 (000) construction and was fully sprinklered except for the Maintenance Supervisor's office closet. The facility has a fire alarm system with smoke detection in the corridors, spaces</p> | K0000 | Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of Federal and State law. | |

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>open to the corridors and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 146 and had a census of 88 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage, but was found in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except the Maintenance Supervisor's office closet. The facility has no detached buildings.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/01/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> | | | |

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| K0018 SS=B | <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 11 corridor doors on Dialysis hall west would latch into its frame. This deficient practice could affect 20 residents on the adjacent corridor as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 09/24/12 at 1:00 p.m. with the Maintenance Supervisor, the door leading into the conference room on Dialysis hall west was equipped with a doorknob and lockset, but it did not latch into its frame. Based on interview on 09/24/12 at 1:05 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned door would not latch into the frame.</p> | K0018 | No residents were found to be affected by this finding. This corrective action will address those residents with the potential to have been affected by this finding. The door latch to the conference room indicated in this finding has been adjusted and the door will secure into door frame without restriction. Maintenance staff will inspect and monitor doors throughout facility through weekly preventive maintenance rounds. Findings will be repaired and or adjusted when identified. | 10/01/2012 | | | |

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| | 3.1-19(b) | | | |

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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>Based on observation and interview, the facility failed to ensure 1 of 2 doors leading to hazardous areas on Dialysis hall west such as rooms with combustible items was provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 20 residents on Office hall east hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 09/24/12 at 1:55 p.m. with the Maintenance Supervisor, the central supply room on Dialysis hall west had sixteen cardboard boxes, the room was greater than fifty square feet in size and was without a self closing device on the corridor door.</p> <p>Based on interview on 09/24/12 at 1:58 p.m. with the Maintenance Supervisor, it</p> | K0029 | <p>No residents were found to be affected by this finding. This corrective action will address those residents with the potential to have been affected by this finding. The maintenance department has installed a self closing device on the door leading into the central supply room located on the west dialysis hall. The closer has been tested and found to function as designed. The maintenance department will continue to monitor through routine facility rounds for issues that have the potential of impacting facility fire/smoke prevention requirements. Rooms utilized for storage will have a door closer installed when appropriate and required.</p> | 09/25/2012 |

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| | <p>was acknowledged the aforementioned door leading into the central supply room was not equipped with a self closing device on the door.</p> <p>3.1-19(b)</p> | | | |

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| K0038 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observations and interview, the facility failed to ensure exit access was arranged so 3 of 11 exit access doors on Office hall were not equipped with 2 locking devices on the doors. Section 19.2.2.2.5 requires means of egress are permitted to be locked, but only one locking device shall be permitted on each door. This deficient practice could affect 1 staff member in each room as well as other visitors and staff in the facility.</p> <p>Findings include:</p> <p>Based on observation on 09/24/12 during the tour between 12:22 p.m. to 12:33 p.m. with the Maintenance Supervisor, the Administration office door on Office hall east, the Bookkeeping office door on Office hall south and the Front office door on Office hall south had a door knob lock and a deadbolt lock on the doors leading out the offices. Based on interview on 09/24/12 concurrent with the observations with the Maintenance Supervisor, it was acknowledged there were two locking devices on all the aforementioned office doors.</p> <p>3.1-19(b)</p> | K0038 | No residents were found to be affected by this finding. This corrective action will address those residents with the potential to have been affected by this finding.1. The deadbolt locks located on the administration office, bookkeeping office, and the front office have been removed despite their not being utilized. The identified doors now have only one locking system per door.2. The exit door ramp located on the west dialysis hall now has a handrail installed at the specified location.The maintenance department has identified no other office doors utilizing two locking mechanisms. Based on rounds with ISDH LSC surveyor, no remaining facility exits were found to require installation of an exit handrail. Exits that meet the criteria already have handrails installed to meet this requirement. | 09/26/2012 | | | |

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| | <p>2. Based on observation and interview, the facility failed to ensure exit access was arranged so that 1 of 19 exits was readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.2.5.4 requires handrails complying with 7.2.2.4 shall be provided along both sides of a ramp run with a rise greater than six inches. LSC Section 7.2.2.4.2 Exception #3 requires an existing ramp shall have a handrail on at least one side. This deficient practice could affect 34 occupants on Parker lane east and west halls as well as visitors and staff if it was necessary to use the the Dialysis west hall exit to evacuate the building.</p> <p>Findings include:</p> <p>Based on observation on 09/24/12 at 02:45 p.m. with the Maintenance Supervisor, the Dialysis hall west exit discharge sidewalk/ramp lacked handrails. The sidewalk was eight feet long and was measured with the Maintenance Supervisor to have a slope of three and three quarter inches to two feet of walkway. Based on interview on 09/24/12 during the measurement at 3:05 p.m. with the Maintenance Supervisor, it</p> | | | |

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| | <p>was confirmed the slope measurement was accurate and no handrails were provided.</p> <p>3.1-19(b)</p> | | | |

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| K0045 SS=E | <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 (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to ensure the lighting in 1 of 19 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. LSC Section 7.8.1.4 requires illumination be arranged so the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. This deficient practice could affect 9 residents observed in the Main dining room as well as staff and visitors if the facility were required to evacuate and the single bulb outside failed leaving the area in darkness.</p> <p>Findings include:</p> <p>Based on observation on 09/24/12 at 2:45 p.m. with the Maintenance Supervisor, there was an exit light on generator back up located outside the Main dining room west exit which only had a single bulb in the light fixture. Based on interview on 09/24/12 at 2:50 p.m., it was acknowledged by the Maintenance</p> | K0045 | No residents were found to be affected by this finding. This corrective action will address those residents with the potential to have been affected by this finding. The facility has replaced the single bulb exterior light fixture located outside the main dining room west exit, with a two bulb fixture which is connected to the back up generator. The maintenance department in rounds with the ISDH LSC surveyor did not identify any other exit light fixtures that require a change. When necessary, maintenance will ensure that only double bulb or dual single bulb fixtures are used as generator back up exit lights. | 09/26/2012 |

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| | Supervisor the outside light providing illumination for the exit discharge out of the west exit of the Main dining room was equipped with only a single bulb light fixture. 3.1-19(b) | | | |

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| K0050 SS=C | <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 of 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports on 09/24/12 with Maintenance Supervisor, the documentation for the drills performed between the hours of 6:00 a.m. and 9:00 p.m. for the past twelve months from 08/11 to 08//12, indicated the fire alarm system had been activated, but the</p> | K0050 | No residents were found to be affected by this finding. This corrective action will address those residents with the potential to have been affected by this finding. The fire drill reporting from has been amended to include documenting and verification that the fire alarm monitoring station received the drill transmission signal. The maintenance department on an ongoing basis will continue to monitor for issues and concerns that may impact fire prevention and safety. Fire drill reports will be maintained to reflect the staff response, specifics of the drill conducted, and verification that the monitoring station received the transmission signal. | 10/02/2012 | | | |

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| | <p>verification of the transmission of the signal was not documented. Based on interview on 09/24/12 during record review, it was acknowledged by Maintenance Supervisor none of the fire drill reports documented the transmission of the signal was received by the monitoring station.</p> <p>3.1-19(b) 3.1-51(c)</p> | | | |

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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>Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 09/24/12 at 3:10</p> | K0051 | No residents were found to be affected by this finding. This corrective action will address those residents with the potential to have been affected by this finding. The fire alarm system circuit breaker located in the electrical room on Parker Lane west hall has been clearly labeled and identified by painting the it red. The color coding of the breaker will allow it to be quickly and immediately identified. The maintenance department on an ongoing basis monitors for issues and concerns that may impact fire prevention and safety. | 09/25/2012 | | | |

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| | <p>p.m. with the Maintenance Supervisor, the fire alarm system circuit breaker was located in a mechanical room on Parker Lane west, but it was not identified. Based on interview on 09/24/12 at 3:15 p.m. with the Maintenance Supervisor, it was acknowledged the breaker for the fire alarm system circuit was not identified.</p> <p>3.1-19(b)</p> | | | |

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| K0056 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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 ensure 1 of 2 closets in the Maintenance office was provided with an automatic sprinkler head to ensure sprinkler coverage in all portions of the building. This deficient practice could affect 20 residents on Parker lane west as well as visitors or staff.</p> <p>Findings include:</p> <p>Based on observation on 09/24/12 at 4:20 p.m. with the Maintenance Supervisor, the small storage closet at the northwest end of the room was not provided with sprinkler coverage. Based on interview on 09/24/12 at 4:22 p.m. with the Maintenance Supervisor, it was acknowledged there were no sprinklers present in the small closet to provide</p> | K0056 | <p>No residents were found to be affected by this finding. This corrective action will address those residents with the potential to have been affected by this finding. A sprinkler head has been installed by a qualified contractor in the maintenance office located on Parker Lane west area. There were no other areas identified in rounds with the ISDH LSC surveyor that lacked placement of a sprinkler head. The maintenance department will continue to monitor and implement modifications to support fire prevention and safety.</p> | 10/12/2012 | | | |

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| | complete sprinkler coverage for the facility. 3.1-19(b) 3.1-19(ff) | | | |

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| K0066 SS=B | <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, record review and interview; the facility failed to ensure cigarette butts were deposited into a noncombustible container specifically for such use instead of a trash container full of paper goods for 1 of 1 areas where smoking was permitted. This deficient practice could affect 9 residents observed in the Main dining room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 09/24/12 at 1:05</p> | K0066 | No residents were found to be affected by this finding. This corrective action will address those residents with the potential to have been affected by this finding. The metal container found to be used for waste disposal in which extinguished smoking materials were found, has been removed. Maintenance department will provide ongoing education for fire prevention to all staff. Designated smoking areas have specific containers for waste and a separate container for disposing extinguished smoking materials. The maintenance | 10/02/2012 | |

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| | <p>p.m. with the Maintenance Supervisor, smoking was permitted just outside the north exit of the Main dining room where over 100 cigarette butts as well as paper goods were observed in a 25 gallon metal trash container. Based on review of the smoking policy on 09/24/12 at 4:45 p.m. with the Maintenance Supervisor, the smoking policy did address the proper disposal of extinguished cigarette butts. Based on interview on 09/24/12 at 1:10 p.m. with the Maintenance Supervisor, it was acknowledged extinguished cigarette butts were thrown into a metal container full of paper goods.</p> <p>3.1-19(b)</p> | | <p>department will continue to monitor and implement modifications to support fire prevention and safety.</p> | |

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| K0067 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 113 of 113 resident rooms were not using the corridor as a portion of a return air system/plenum for the heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect all residents as well as visitors and staff in the facility.</p> <p>Findings include:</p> <p>Based on observations on 9/24/12 during a tour of the facility between 11:33 a.m. and 4:14 p.m. with the Maintenance Supervisor, all resident rooms on Station 1, Station 2, Station 3 and Station 4 were using the egress corridors as a return air system. Based on interview on 09/24/12 concurrent with the observations with the Maintenance Supervisor, it was confirmed the return air was exhausted into the</p> | K0067 | The Heritage House of Shelbyville respectfully requests continuance of the waiver for this finding. Smoke detectors are located in the areas identified in this finding. Activation of the fire alarm system will trigger relays that shut down the air handlers in the areas of the facility referenced in this finding. Once the air handler is closed, smoke will be prevented from transferring from one smoke zone to another. Modifications to the existing air handling system will pose a hardship for residents displaced during the installation process. The facility would also incur financial hardship for an estimated cost of \$59,000 conservatively to upgrade the air handling system to meet this requirement. The history of the facility reflects no incidents resulting from this finding. See waiver request letter dated 9/25/12 Attachment A | 09/25/2012 | | | |

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| | corridor for the aforementioned adjoining rooms. 3.1-19(b) | | | |

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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 provide storage locations for 2 of 2 liquid oxygen supply tanks containing fifty seven hundred and fifty five cubic feet per fifty gallons each in locations which would protect them from the weather. NFPA 99, 4-3.5.2.2 requires cylinders stored in the open shall be protected against extremes of weather. During winter, cylinders stored in the open shall be protected from an accumulation of ice or snow. In summer, cylinders stored in the open shall be screened against continuous exposure to direct rays of the sun in those localities where extreme temperatures prevail. This deficient practice could affect 9 residents observed in the adjacent dining room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 09/24/12 at 2:05</p> | K0076 | No residents were found to be affected by this finding. This corrective action will address those residents with the potential to have been affected by this finding. The maintenance department has constructed an enclosure to cover the pair of 50 gallon LS180 liquid oxygen tanks which are located outside the west kitchen exit. The tanks have remained in the present location for several years and were not previously identified to be an issue. The constructed enclosure will provide protection for the liquid oxygen tanks from exposure to elements. The maintenance department and facility respiratory therapist will monitor for and address issues when identified related to medical gas storage to ensure they meet standards of compliance. | 10/03/2012 | |

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| | <p>p.m. with the Maintenance Supervisor, two 50 gallon LS180 liquid oxygen tanks were located against the outside wall immediately south of the kitchen's west exit exposed and unprotected from the elements. No enclosures were provided for protection from sun, snow, or rain. Based on interview on 09/24/12 at 2:07 p.m. with the Maintenance Supervisor, it was agreed the oxygen tanks were exposed to all types of weather.</p> <p>3.1-19(b)</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 2 oxygen storage rooms where oxygen transfer occurs was separated within a one hour fire barrier enclosure. This deficient practice could affect 30 residents on Northeast hall as well as visitors and staff near the oxygen storage room.</p> <p>Findings include:</p> <p>Based on observation on 09/24/12 at 12:22 p.m. with the Maintenance Supervisor, the door to the oxygen transfer room on Northeast hall had a manufacturer's tag which verified it to be a twenty minute fire rated door. Based on interview on 09/24/12 at 12:23 p.m. it was acknowledged by the Maintenance</p> | K0143 | <p>No residents were found to be affected by this finding. This corrective action will address those residents with the potential to have been affected by this finding. The door located on the northeast hall that opens to the oxygen transfer room has been exchanged by the maintenance department with a door that has a manufacturer rating tag showing a fire rating of 1 1/2 hour which exceeds the 1 hour requirement. The maintenance department with the ISDH LSC surveyor have inspected all doors that are used to store and transfer oxygen. Remaining areas with doors opening to an oxygen transfer room were found to be compliant with a door appropriately fire rated based on the manufacturer fire rating tag.</p> | 10/02/2012 | |

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| | Supervisor oxygen transfer occurs in the storage room and the fire rating of the corridor door to the oxygen transfer room was a twenty minute door. 3.1-19(b) | | The maintenance department on an ongoing basis monitors for issues and concerns that may impact fire prevention and safety. | |