

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/27/2016
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NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
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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: 07/27/16</p> <p>Facility Number: 000108 Provider Number: 155653 AIM Number: 100267410</p> <p>At this Life Safety Code Survey, Lake County Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2</p> <p>This two story facility determined to be of Type II (222) construction was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and in areas opened to the corridors. Battery operated smoke detectors are installed in all resident sleeping rooms. The facility has a</p>	K 0000	<p>August 12, 2016</p> <p>Kim Rhoades, Director of Long Term Care Indiana State Department of Public Health 2 North Meridian St. Sec 4-B Indianapolis, In 46204-3006</p> <p>Dear Ms.Rhoades:</p> <p>Please reference the enclosed 2567 as "Plan of Correction" for the July 27, 2016 Life Safety code Survey Recertification that was conducted at Lake County Nursing and Rehabilitation Center. I will submit signature sheets of the in-servicing, content of in-service and audit tools</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>capacity of 117 and a census of 58 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two detached storage sheds.</p> <p>Quality Review completed on 08/01/16 - DA</p>		<p>August 12, 2016. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community.</p> <p>The Plan of Correction submitted on August 12, 2016 serves as our allegation of compliance. The provider respectfully request a Desk review on or after August 26, 2016. Should you have any question or concerns regarding the Plan of Corrections, please contact me.</p> <p>Respectfully,</p>	

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K 0018 SS=E Bldg. 01	<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>1. Based on observation and interview, the facility failed to ensure 1 of 1 MDS and 1 of 1 Buiness office corridor door did not have an impediment to latching. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the</p>	K 0018	<p>Neysa Stewart, HFA</p> <p><b>K018 PLAN OF CORRECTION</b> Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. 1. The corrective action taken for the resident found to have been affected by the deficient practice: No visitors, staff or residents residing in the facility</p>	08/11/2016

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	<p>Environmental Director on 07/27/16 at 11:31 a.m. then again at 12:44 p.m., the corridor door to the MDS office had a door stop that prevented the corridor door from closing and latching into the door frame. Then again, the corridor door to the Business office had a door stop that prevented the corridor door from closing and latching into the door frame. Based on interview at the time of each observation, the Maintenance Director and the Environmental Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 56 resident rooms, 1 of 1 Janitor's closet and 1 of 1 Unmarked Clothing room corridor doors would resist the passage of smoke. This deficient practice could affect staff and up to 23 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Environmental Director on 07/27/16 between 12:37 p.m. and 12:36 p.m., the following was discovered:</p> <p>a) the Janitor's closet corridor door contained two separate quarter inch</p>		<p>were identified as being adversely affected. 1)“Based on observation and interview, the facility failed to ensure 1 of 1 MDS Office and 1 of 1 Business Office corridor door did not have an impediment to latching. 2) Based on observation and interview the facility failed to ensure 1 of 56 resident rooms, 1 of 1 Janitor’s Closet and 1 of 1 unmarked Clothing room corridor doors would resist the passage of smoke. The maintenance director immediately educated the MDS Nurse and the Business Office Manager and removed the stoppers. He also repaired / sealed the door penetrations in the Janitor’s closet, unmarked Clothing room and resident room 101 corridor. <b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b> All visitors, staff and residents residing in the facility have the potential to be affected. No visitors, staff or residents were identified. Any concerns will be addressed immediately. <b>3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur:</b> The MDS Nurse, Business Office manager and all Department Heads were in-serviced on 7/27/16 by the Maintenance Director regarding not using stoppers to keep door open. The Maintenance Director conducted a facility wide audit to</p>	

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K 0029 SS=E Bldg. 01	<p>penetrations. b) resident room 101 corridor door had a quarter inch penetration c) the Unmarked Clothing room corridor door contained two separate quarter inch penetrations. Based on interview at the time of each observation, the Maintenance Director and the Environmental Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Room 2-1 storage room</p>	K 0029	<p>ensure all doors are free of penetrations and door stoppers. <b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b> Maintenance Director / Designee will audit <b>10 facility doors (5 rooms on 1st Floor &amp; 5 rooms on 2nd Floor) weekly for 4 weeks</b> and then <b>5 facility doors for 2 months</b> to ensure they are free of door stoppers and penetrations. Any issues identified will be addressed immediately. The audit will be presented and reviewed monthly at the Quality Assurance meeting for the next 3 months QA committee will determine if continued auditing is necessary. <b>5. Completion date systemic changes will be completed: 8/11/16</b></p> <p><b>K029 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of</b></p>	08/11/2016

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	<p>greater than 50 feet squared, a hazardous area, would positively latch into the frame. This deficient practice could affect staff and up to 11 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Environmental Director on 07/27/16 at 11:45 a.m., room 2-1 contained at least ten large cardboard boxes, 20 large foam pads, ten wheelchairs, and other storage. The corridor door failed to latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director and the Environmental Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 fuel fired Laundry, a hazardous area, would positively latch into the frame. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Environmental Director on 07/29/16 at</p>		<p><b>correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</b> 1. <b>The corrective action taken for the resident found to have been affected by the deficient practice:</b> No residents, staff or visitors were identified as being adversely affected. <b>“Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Room 2-1 storage room and 1 of 1 fuel fire laundry would positively latch into the frame”.</b> a. The Maintenance Director immediately repaired door’s self-closures in room 2-1 storage room and the fuel fire Laundry room to ensure that the doors positively latch into the frame.</p> <p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b> All visitors, staff, and residents residing in the facility have the potential to be affected. Any concerns will be addressed immediately. <b>3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur:</b> The Maintenance Director or designee will conduct an audit monthly of the 10 facility self-closing doors to ensure they positively latch into the frame. Any door requiring</p>	

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K 0048 SS=F Bldg. 01	<p>12:25 p.m., the Laundry room contained fuel fired dryers. The corridor door failed to latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director and the Environmental Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire</p>	K 0048	<p>additional repairs will be repaired in a timely manner. The Maintenance Department was educated on the importance of ensuring that all self-closing doors positively latch into the frame. <b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b> Maintenance Director or Designee will audit <b>10</b> facility self-closing doors <b>monthly</b> to ensure they positively latch into the frame. The audits will be presented and reviewed for the next 3 months during our monthly QA meeting. QA committee will determine if continued auditing is necessary once compliance threshold is achieved. This plan to be amended when indicated. <b>5. Completion date systemic changes will be completed: 8/11/16</b></p> <p><b>K048 PLAN OF CORRECTION</b> Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. <b>1. The corrective action taken for</b></p>	08/11/2016

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	<p>department</p> <p>(3) Response to alarms</p> <p>(4) Isolation of fire</p> <p>(5) Evacuation of immediate area</p> <p>(6) Evacuation of smoke compartment</p> <p>(7) Preparation of floors and building for evacuation</p> <p>(8) Extinguishment of fire</p> <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a record review and interview on 07/27/16 at 1:00 p.m., the Maintenance Director and the Environmental Director acknowledged the "Fire Safety and Evacuation Plan" did not address (7) Preparation of floors and building for evacuation.</p> <p>3.1-19(b)</p>		<p><b>the resident found to have been affected by the deficient practice:</b> No visitors, staff or residents residing in the facility were adversely affected. 1. Based on record review and interview, the facility failed to provide a written plan the addressed all the components in 1 of 1 written fire plans. The Maintenance Department and Environmental Director were re-educated on the location of the written Evacuation Plan and a copy was given to the Maintenance Director to place in the emergency binder immediately. 2. <b>The corrective action for those residents having the potential to be affected by the same deficient practice:</b> All staff, visitors, and residents residing in the facility have the potential to be affected by the alleged deficient practice. Any concerns will be addressed immediately. 3. <b>The measures put into place and a systemic change made to ensure the deficient practice does not reoccur:</b> The Maintenance Director and the Environmental Director was re-educated on location of the facility written Evacuation Plan by the Administrator on 7/28/16. 4. <b>To ensure the deficient practice does not reoccur, the monitoring system established is to:</b> Administrator / Designee will monitor the Maintenance</p>	

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K 0054 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm system was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be</p>	K 0054	<p>binder monthly for 3 months to ensure the written Evacuation Plan is in the binder. Any issues found will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once compliance threshold is achieved. This plan to be amended when indicated.</p> <p><b>5. Completion date systemic changes will be completed: 8/11/14</b></p> <p><b>K054 PLAN OF CORRECTION</b> Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b> No visitors, staff or residents residing in the facility were adversely affected.</p> <p>"Based on the interview and record review no sensitivity was available for review". Esco Communication was out on 6/28/16 &amp; 6/30/16 to make</p>	08/11/2016

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	<p>extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method</li> <li>(2) Manufacturer's calibrated sensitivity test instrument</li> <li>(3) Listed control equipment arranged for the purpose</li> <li>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</li> <li>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</li> </ol> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the</p>		<p>repairs to the Fire Panel annunciator. Koorsen Fire Alarm System completed the sensitivity test on 8/2/16. <b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b> This deficient practice could affect all residents, staff, and visitors. No residents, staff or visitors were identified as being adversely affected. <b>3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur:</b> The facility will ensure that sensitivity test are completed quarterly and ensure the facility has received the report from Koorsen. <b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b> Maintenance Director / Designee will monitor the completion of the sensitivity test quarterly for 6 months to ensure that the sensitivity test is completed timely and facility has received the report. Any issues found will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once compliance threshold is achieved. This plan to be amended when indicated. <b>5. Completion date systemic changes will be completed:</b></p>	

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K 0064 SS=E Bldg. 01	<p>Maintenance Director and the Environmental Director on 07/27/16 between 1010 a.m. and 10:55 a.m., no sensitivity test was available for review. Based on interview at the time of record review, the Maintenance Director and the Environmental Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguisher near resident room 128 pressure gauge readings was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect up to 15 residents.</p> <p>Findings include:</p>	K 0064	<p>8/11/16</p> <p><b>K064</b></p> <p><b>PLAN OF CORRECTION</b></p> <p><b>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</b></p>	08/11/2016

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	<p>Based on observation with the Maintenance Director and the Environmental Director on 07/27/16 at 11:48 a.m., the gauge on the portable fire extinguisher located near resident room 128 indicated the extinguisher was undercharged. Based on interview at the time of observation, the Maintenance Director and the Environmental Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 2 portable type K kitchen fire extinguishers was installed correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the</p>		<p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b> No visitors, staff or residents residing in the facility were identified as being adversely affected.</p> <p>"Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguishers near resident room 128 pressure gauge readings was in the acceptable range".</p> <p>The fire extinguisher near resident room 128 was replaced on 7/27/16.</p> <p>"Based on observation with the Maintenance Director and the Environmental Director the kitchen type K extinguishers both measured 66 inches from the top of the extinguisher to the floor".</p> <p>On 7/27/16 both extinguishers were lowered to 60 inches above the floor from the top of the extinguishers.</p> <p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b></p>	

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	<p>Environmental Director on 07/27/16 at 12:36 p.m., the kitchen type K fire extinguishers both measured 66 inches from the top of the extinguisher to the floor. Based on interview at the time of observation, the Maintenance Director and the Environmental Director acknowledged each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p>		<p>All visitors, staff and residents residing in the facility have the potential to be affected. Any concerns will be addressed immediately.</p> <p><b>3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur:</b></p> <p>The maintenance department was re-educated on the importance of ensuring that all fire extinguishers are fully charged on 7/28/16 by the Administrator. The Maintenance Director or designee will conduct an audit twice a month for 2 months and then monthly for 2 months of facility fire extinguishers to ensure they are fully charged.</p> <p><b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b></p> <p>Maintenance Director / Designee will conduct an audit twice a month for 2 months and then monthly for 2 months of facility fire extinguisher gauge to ensure they are fully charged</p>	

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K 0130 SS=E Bldg. 01	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review and interview, the facility failed to maintain 1 of 56 single station battery operated smoke alarms. This deficient practice affects staff and at least 11 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Environmental Director on 07/27/16 at 12:51 p.m., resident room 210 did not have a smoke alarm installed. Based on interview at the time of observation, the Maintenance Director</p>	K 0130	<p>appropriately. Any issues identified will be addressed immediately. The audit will be presented and reviewed monthly for the next 4 months at the Quality Assurance meeting. QA committee will determine if continued auditing is necessary.</p> <p><b>5. Completion date systemic changes will be completed: 8/11/16</b></p> <p><b>K130</b></p> <p><b>PLAN OF CORRECTION</b></p> <p><b>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory</b></p>	08/11/2016

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	<p>and the Environmental Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to maintain 2 of 56 single station battery operated smoke alarms. This deficient practice affects staff and at least 11 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Environmental Director on 07/27/16 at 10:55 a.m. then again at 12:51 p.m., resident room 217 smoke alarm battery tray was hanging out. When the battery was put back in, the smoke alarm failed to provide an audible test sound when tested. Then again, resident room 212 smoke alarm failed to provide an audible test sound when tested.</p> <p>Based on interview at the time of each observation, the Maintenance Director and the Environmental Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p><b>requirement.</b></p> <p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b> No residents, staff or visitors were adversely affected.</p> <p>1. "Based on record review and interview, the facility failed maintain 1 of 56 single station battery operated smoke alarms".</p> <p>2. "Based record review and interview, the facility failed to maintain 2 of 56 single smoke alarms".</p> <p>1. On 7/27/16 the Maintenance Department replaced the missing smoke alarm in resident room 210.</p> <p>2. New batteries were installed in resident rooms 217 and 212 and tested for audible sound by the Maintenance Department on 7/27/16.</p> <p><b>2. The corrective action for those residents having the potential to be affected by the</b></p>	

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			<p><b>same deficient practice:</b></p> <p>All staff, visitors, residents residing in the facility have the potential to be affected. No visitors, staff or residents were identified. Any concerns will be addressed immediately.</p> <p><b>3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur:</b></p> <p>The Maintenance Director conducted a facility wide audit to ensure smoke alarms are in all resident sleeping rooms and has an audible sound. No other resident rooms were identified. On 7/28/16 the Administrator in-serviced the Maintenance Department on the importance of testing the smoke alarms for audible sound and missing smoke alarms in resident rooms. Any issues identified will be addressed immediately.</p> <p><b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</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</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 21</p>	K 0147	<p>Maintenance Director / Designee will audit 10 resident rooms weekly for 4 weeks, then 5 resident rooms twice a month for 3 months to ensure smoke alarms are present and operating properly. Any issues found will be addressed immediately. The audits will be discussed for the next 4 months during our monthly QA meeting. QA committee will determine if continued auditing is necessary once compliance threshold is achieved. This plan to be amended when indicated.</p> <p><b>5. Completion date systemic changes will be completed: 8/11/16</b></p> <p><b>K147</b></p> <p><b>PLAN OF CORRECTION</b></p> <p><b>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility</b></p>	08/11/2016

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	<p>residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Environmental Director on 07/27/16 at 11:53 a.m. then again at 12:04 p.m., a surge protector was powering a refrigerator in resident room 123. Then again, a surge protector was powering a microwave and a refrigerator in Therapy. Based on interview at the time of each observation, the Maintenance Director and the Environmental Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain an electrical outlet in 1 of 56 resident rooms. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff and at least 17 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and the</p>		<p><b>and is submitted only in response to the regulatory requirement.</b></p> <p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b></p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for wiring. Power strip extension cords were located:</p> <p>a. Resident room 123 -refrigerator connected to surge protector</p> <p>b. Therapy- surge protector powering a microwave and refrigerator</p> <p>a. Resident room 123: the refrigerator was disconnected from the flexible cord / surge protector and relocated to a different area in the room and plugged directly into the wall outlet.</p> <p>b. Therapy: the microwave and refrigerator was relocated to a different area in the room and plugged directly into the wall</p>	

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	<p>Environmental Director on 07/27/16 at 11:52 a.m., resident room 124 electrical outlet was missing a cover. Based on interview at the time of observation, the Maintenance Director and the Environmental Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>outlet.</p> <p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b></p> <p>All staff, visitors, and residents residing in the facility have the potential to be affected by the alleged deficient practice. No visitors, staff or residents were identified. Any concerns will be addressed immediately.</p> <p><b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b></p> <p>The Maintenance Director conducted a facility wide visual audit to ensure no further extension cord or surge protectors are used inappropriately.</p> <p>Department Heads and All staff were in-serviced regarding inappropriate use of power strips. Staff was educated that power strips cannot be used as a substitution for electrical wiring on 7/27/16 &amp; 7/28/16 by Maintenance Director.</p> <p><b>4. To ensure the deficient practice does not reoccur, the</b></p>	

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			<p><b>monitoring system established is to:</b></p> <p>Maintenance Director / Designee will audit department head's office, Resident rooms and Therapy Department twice a month for 3 months to ensure flexible cords are not used as a substitute for wiring, electrical power strips are used properly. Any issues found will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once compliance threshold is achieved. This plan to be amended when indicated.</p> <p><b>Completion date systemic changes will be completed: 8/11/16</b></p>	