

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155776	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/20/2013
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NAME OF PROVIDER OR SUPPLIER SPRINGHILL VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 E SPRINGHILL DR TERRE HAUTE, IN 47802
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K010000	<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: 11/20/13</p> <p>Facility Number: 012188 Provider Number: 155776 AIM Number: 200958030</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Springhill 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 18, New 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 and in spaces open to the corridors. Resident rooms are equipped with battery powered smoke</p>	K010000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review on or after 12-20-13.	

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>detectors. The facility has a capacity of 99 and had a census of 96 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. Two detached buildings used for nursing supply storage and maintenance were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/02/13.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>				

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure a door protecting a corridor opening in 1 of 7 smoke compartments would latch into the door frame. This deficient practice affects staff, visitors and 20 or more residents in the 100 wing smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/13 at 11:00 a.m., the door to resident room 103 failed to latch into the door frame when tested twice. The maintenance director acknowledged at the time of observation, the door was not latching.</p> <p>3.1-19(b)</p>	K010018	<p>K 018 NFPA 101 Life Safety Codelt is the policy of this facility that all doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practiceThe Maintenance Director, will ensure that all doors latch into the door frame, ensuring life safety code is met. The door to Room 103 was immediately corrected by the Maintenance Director. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be takenResidents that reside at the facility may be affected by alleged deficient practice. All other doors were checked by Maintenance Director on 11/20/2013. Staff educated by Executive Director on 12/10/2013 that door must latch into frame and to report to Maintenance Director immediately if doors were not latching properly. What measures will be put into place or what systemic changes you will make</p>	12/20/2013	

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			to ensure that the deficient practice does not recur Maintenance Director will check doors to ensure they latch appropriately weekly X 4 weeks and then return to monthly with scheduled fire drill. CQI committee will review quarterly. Executive Director or Designee to monitor. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Staff educated on 12/10/2013 that door must latch into frame and to report to Maintenance Director immediately if doors were not latching properly.		

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure openings in ceiling smoke partitions were sealed to limit the transfer of smoke in 2 of 7 smoke compartments. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke. This deficient practice could affect visitors, kitchen staff and 10 or more residents in the 200 hall smoke compartment.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 11/20/13 at 10:10 a.m., a one half inch gap was found in the 400 hall smoke barrier above the lay in ceiling where caulk had become dislodged and fallen away from a wiring penetration. The maintenance director acknowledged at the time of observation, the gap should be resealed.</p> <p>b. Based on observation with the</p>	K010025	<p>K025 NFPA Life Safety Code Standard It is the policy of this facility that smoke barriers are constructed to provide at least a one-hour fire resistant rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The gap in the 400 hall smoke barrier above the lay in the ceiling was resealed on 11/21/13 by the Maintenance Supervisor. The gap around the pendant sprinkler head in room 209 and the sprinkler head in the kitchen</p>	12/20/2013			

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	<p>maintenance director on 11/20/13 between 10:35 a.m. and 12:45 p.m., there was a one fourth inch annular gap around a pendant sprinkler head in resident room 209 and a three fourths inch gap around a pendant sprinkler head in the kitchen dish room. The maintenance director acknowledged at the time of observations, the gaps should have been sealed.</p> <p>3.1-19(b)</p>		<p>dish room corrected on 11/21/2013 by the Maintenance Supervisor. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be takenResidents that reside at the facility may be affected by alleged deficient practice.All smoke partitions were checked by the Maintenance Supervisor on 11/21/2013 to ensure no gaps are present. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recurThe Maintenance Director will check all smoke partitions for gaps weekly and reseal as necessary. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placeCQI tool will be initiated to monitor gaps in the ceiling smoke partitions weekly for four weeks and monthly for two months, and quarterly there after.CQI Committee will review quarterly.Executive Director or Designee to monitor.</p>		

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K010038 SS=D	<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. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure egress for 1 of 2 kitchen exits was arranged to be accessible. LSC 18.2.1 requires compliance with LSC 7, Means of Egress. LSC 7.1.3.2.3 requires an exit enclosure shall not be used for any purpose with the potential to interfere with its use as an exit. LSC 7.1.10.1, "Means of egress shall be continuously free of all obstructions or impediments to full instant use in case of fire or other emergency use." This deficient practice affects 4 kitchen staff and any kitchen visitors.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/13 at 12:25 p.m., the egress path for the back kitchen exit was cluttered with five empty cardboard boxes on the floor and three empty milk crates which diminished the egress width to two feet in one area. The maintenance director said at the time of observation, the items were "not usually kept there." The area was observed again at 1:30 p.m. on 10/20/13, and the clutter had not yet been removed.</p>	K010038	<p>K 038 NFPA 101 Life Safety Code StandardIt is the policy of this facility that all exit access is arranged so that exits are readily accessible at all times. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.The clutter impeding the egress path for the back kitchen exit was removed immediately. All staff was educated that during delivery and stocking the egress path must be left clear of clutter. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be takenResidents that reside at the facility may be affected by alleged deficient practice. All staff was educated by the Executive Director on 12/10/2013 to leave egress for all exits clear of clutter. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recurThe Management Team has been educated to watch for clutter at the egress and remove immediately.Signage was posted to leave egress clear at all times. How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</p>	12/20/2013			

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	3.1-19(b)		i.e., what quality assurance program will be put into place.CQI tool will be used weekly X 4 weeks, monthly X 2 months and quarterly thereafter.CQI Committee will review quarterly.Executive Director or Designee to monitor.		

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K010048 SS=E	<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. 18.7.1.1 Based on observation, record review and interview; the facility failed to train staff to implement the plan for staff response for evacuation of 24 of 24 residents from the 400 hall. LSC 18.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affects staff, visitors and 24 residents on the 400 hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/13 at 10:15 a.m., a padlock secured the gate between the exit discharge from the 400 hall and the evacuation point of the driveway beyond the six foot fence. A box located adjacent to the gate contained a key for opening the padlock with</p>	K010048	<p>K048 NFPA 101 Life SafetyIt is the policy of this facility that there is a written plan for the protection of all patients and for their evacuation in the event of an emergency. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practiceAll staff was educated on 12/10/2013 be the Executive Director regarding the proper evacuation procedure through the courtyard gates on 400 hall and the Main Dining. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents that reside at the facility may be affected by alleged deficient practice.All staff will be educated upon hire and at least annually on the proper evacuation procedure through the courtyard gates on 400 hall and the Main Dining Room. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.Signage has been posted on the affected exit doors with the procedure of how to evacuate through the gate if necessary. The Maintenance Director will check weekly X 4 weeks, monthly X 2 months and</p>	12/20/2013			

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	<p>instructions to break the glass to access the key. CNA # 1 was asked on 11/20/13 at 10:16 a.m. with the maintenance director, to identify the means by which she would evacuate residents through the gate if necessary. She appeared confused when she approached the gate and found it padlocked. She said she had not been aware of the padlock on the gate. The maintenance director confirmed at the time of interview, he instructed staff during orientation to move residents to another smoke compartment rather than outside in the event of an emergency and he had not provided training for access through the gate.</p> <p>3.1-19(b)</p>		<p>quarterly therefore to ensure signs are in place. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.CQI tool will be used weekly X 4 weeks, monthly X 2 months and quarterly thereafter.CQI Committee will review quarterly.Executive Director or Designee to monitor.</p>		

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K010062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 7 smoke compartments and under the main entrance/exit canopy were free of corrosion and foreign materials such as paint. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 10 or more residents in the 200 hall smoke compartment and anyone using the main entrance/exit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/13 between 10:00 a.m. and 2:00 p.m.:</p> <p>a. Four sprinkler heads under the main entrance/exit canopy were turning green, usually evidence of corrosion;</p> <p>b. One sprinkler head in resident room 217 had flecks of paint on it;</p> <p>c. Four sprinkler heads in resident room 218 had a white material on them which the maintenance director identified as drywall spackling at the time of observation. He agreed at the time of</p>	K010062	<p>K062 NFPA 101 Life Safety Code Standard It is the policy of this facility that automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice All sprinkler heads under the main entrance/exit canopy were inspected by P.I.P.E, Inc. on 11/20/2013 and a proposed quote to replace all sprinkler heads was received. The new sprinkler heads were ordered by P.I.P.E, Inc. on 11/21/2013 and will be installed by P.I.P.E. as soon as supplies are received. Sprinkler heads in room 217 and 218 were serviced by the Maintenance Director and all foreign materials were removed. Items on the shelf were removed and dietary staff was educated on storing items at a minimum of 18 inches below the sprinkler system. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents that reside at the facility may be affected by alleged</p>	12/20/2013			

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	<p>observations, the foreign materials and corrosion could affect the reliability of the sprinkler head's function.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 kitchen freezer sprinkler heads was free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice affects visitors and 4 occupants in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/13 at 12:20 p.m., the storage on shelves in the kitchen freezer was located six inches from the only sprinkler head providing protection for the space. The maintenance director acknowledged at the time of observation, the sprinkler head was less than the minimum distance allowed between a sprinkler head and obstruction.</p>		<p>deficient practice. All sprinkler heads were inspected by the Maintenance Director to ensure that no foreign materials were present. P.I.P.E, Inc to replace necessary sprinkler heads. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Maintenance Director will check the CQI tool will be completed monthly by the Maintenance Supervisor to ensure that no foreign material is present on sprinkler heads and that the integrity of the sprinkler heads is not compromised. A monitoring tool will be completed daily by the Dietary Manager to ensure storage in the walk in freezer is at least 18 inches from sprinkler heads. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. CQI committee will review quarterly. Executive Director or Designee to monitor</p>		

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K010066 SS=D	<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. 18.7.4</p> <p>Based on observation, interview, and record review; the facility to provide a written smoking policy and provide a self closing metal container for the emptying of ashtrays in 2 of 2 areas behind the facility where smoking occurred. This deficient practice affects 2 or more staff, visitors or resident who might make use of the area commonly used for smoking.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/13 at</p>	K010066	<p>K066 NFPA 101 Life Safety Code StandardIt is the policy of this facility that smoking regulations are adopted and include no less than the following provisions: (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.(2) Smoking by patients classified as not responsible is prohibited, except</p>	12/20/2013

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NAME OF PROVIDER OR SUPPLIER SPRINGHILL VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1001 E SPRINGHILL DR TERRE HAUTE, IN 47802			
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	<p>12:30 p.m., the ground between the emergency generator and an adjacent unsprinklered storage building was carpeted with a layer of dead grass and an accumulation of cigarette butts. A nearby outdoor seating area was occupied by a staff member who was smoking and using one of two ashtrays located there. The ground surrounding the site was littered with cigarette butts. The maintenance director said at the time of observations, the space beside the generator was not designated for smoking and smokers usually went to the site where the smoker was observed. He said the campus was supposed to be nonsmoking. Reviewed with the maintenance director on 11/20/13 at 2:20 p.m., page 24 of the disaster manual was the second page of the Fire Watch Policy and Procedure and made reference to smoking. It noted: "Upon initiation of a Firewatch - this facility will adhere to a strict no smoking policy on or around the owned property - including outdoors...." Per interview with the administrator on 11/20/13 at 2:25 p.m., the facility was non smoking and there was no written smoking policy available for review.</p> <p>3.1-19(b)</p>		<p>when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practiceThe Maintenance Director cleared the ground between the emergency generator and the adjacent storage building as well as the staff smoking area of all cigarette butts on 11/20/13. All staff was educated by the Executive Director regarding the approved staff smoking area on 12/10/2013. No smoking will be allowed in any other locations. All staff was also educated on proper disposal of cigarette butts into approved containers on 12/10/2013. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents that reside at the facility may be affected by alleged deficient practice.Ashtrays of non-combustible material and safe design were provided at staff smoking area on 11/21/2013.Metal containers with self closing cover into which ashtrays can be emptied were provided at staff smoking</p>				

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			<p>area. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recurThe Maintenance Director/Designee will monitor the staff smoking location to ensure cigarette butts are disposed of correctly.Ashtrays of non-combustible material and safe design were provided at staff smoking area.Metal containers with self closing cover into which ashtrays can be emptied were provided at staff smoking area. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placeCQI tool will be completed weekly X 4 weeks, monthly X 2 weeks and then quarterly. CQI committee will review quarterly.Executive Director or Designee to monitor. K070 NFPA Life Safety Code StandardIt is the policy of this facility that portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practiceThe space heater was immediately removed from the medical records office. How will you identify other residents</p>		

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			having the potential to be affected by the same deficient practice and what corrective action will be takenResidents that reside at the facility may be affected by alleged deficient practice. All staff was educated on 12/10/2013 by the Executive Director that space heaters are not permitted to be used in the facility.The Maintenance Supervisor inspected every office in the building and department managers were educated that space heaters were not permitted. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recurThe Maintenance Director will check all areas of the building to ensure no space heaters are present and being used. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placeCQI tool to be completed weekly X 4 weeks, monthly X 2 then quarterly. Management staff will continue to observe for no use space heaters.CQI Committee will review quarterly.Executive Director or Designee to monitor.		

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K010070 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 18.7.8</p> <p>Based on observation and interview, the facility failed to provide evidence 1 of 1 space heaters was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice could affect visitors, staff and 10 or more residents in the main dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/13 at 11:25 a.m., a space heater was stored in the medical records office. The maintenance director said at the time of observation space heaters were not to be used. The administrator was interviewed on 11/20/13 at 2:15 p.m. and confirmed the use of space a heater was not permitted and she had no written policy and procedure to govern it's use.</p> <p>3.1-19(b)</p>	K010070	<p>K070 NFPA Life Safety Code StandardIt is the policy of this facility that portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practiceThe space heater was immediately removed from the medical records office. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be takenResidents that reside at the facility may be affected by alleged deficient practice. All staff was educated on 12/10/2013 by the Executive Director that space heaters are not permitted to be used in the facility.The Maintenance Supervisor inspected every office in the building and department managers were educated that space heaters were not permitted. What measures will be put into place or what systemic changes you will make to ensure</p>	12/20/2013	

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			that the deficient practice does not recurThe Maintenance Director will check all areas of the building to ensure no space heaters are present and being used. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placeCQI tool to be completed weekly X 4 weeks, monthly X 2 then quarterly. Management staff will continue to observe for no use of space heaters.CQI Committee will review quarterly.Executive Director or Designee to monitor.		

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K010074 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 18.7.5.1, 1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3), 10.3.4, 18.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure window curtains/valances in 1 of 7 smoke compartments were rendered flame resistant. LSC 18.7.5.1 requires draperies and other loosely hanging fabrics to be in accordance with 10.3.1. LSC 10.3.1 requires draperies, curtains, and other similar loosely hanging furnishings and decorations to have flame resistance as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice affects visitors, staff and 10 or more residents in the main dining room smoke compartment.</p>	K010074	K074 NFPA 101 Life Safety Code StandardIt is the policy of this facility that all draperies, curtains, including cubicle curtains and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practiceAll window treatment/draperies in the building were inspected for a flame resistant label by the Maintenance Director	12/20/2013			

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	<p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/13 between 11:30 a.m. and 12:30 p.m., flame resistance labeling was not found on the main dining room window curtains and the valance in the dietary kitchen. The maintenance director said at the time of observations, he had no evidence these specific materials were treated to make them flame resistant. He provided a document on 11/20/13 at 1:45 p.m. dated September 2009. The document noted: "All Window treatment/drapery was treated as directed with FireGuard flame retardant." An attachment was provided with the fire protection properties of the fire retardant. The maintenance director acknowledged there was no means to identify what material was treated, by whom, the date of treatment and whether a new fabric may have been added and treated or not.</p> <p>3.1-19(b)</p>		<p>andHousekeeping/Laundry Supervisor. Those that were found to not have a flame resistant label were treated. The date of treatment, time of treatment, and by whom the treatment was completed was documented on 12/11/2013. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be takenResidents that reside at the facility may be affected by alleged deficient practice. All management staff was educated on 12/10/2013 by Executive Director that when new window treatment/ draperies are used they must be treated with flame retardant spray and the documentation must be completed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recurAll new window treatment/draperies will be given to the Housekeeping/ Laundry Supervisor for proper treatment prior to installation if a flame resistant label is not already in place. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placeCQI tool will be completed weekly X 4 weeks, monthly X 2 months and quarterly to ensure new window coverings that have not been treated are not</p>		

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			present. All management staff will continue to monitor for flame resistant labels. The CQI Committee will review quarterly. Executive Director or Designee to monitor.		

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K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure electrical wiring connections were maintained in a safe operating condition which included junction boxes in 2 of 7 smoke compartments. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect visitors, staff and 30 or more residents in 100 and 400 hall smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/13 between 10:00 a.m. and 2:00 p.m., junction boxes above the lay in ceiling near the 100 hall and 400 hall smoke barriers were uncovered with multiple wires exposed. The maintenance director said at the time of observations, he was unaware the boxes had not been covered.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed</p>	K010147	<p>K147 NFPA 101 Life Safety Code StandardIt is the policy of this facility that electrical wiring and equipment is in accordance with NFPA 70, National Electric Code 9.1.2 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practiceCovers were replaced on the junction boxes in the ceiling lay above the 100 and 400 halls on 11/21/2013. The power strip extension cord in the Physical Therapy storage closet and East Medication Room was removed on 11/20/2013.The extension cord was removed from the MDS Office and room 206 on 11/20/2013. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be takenResidents that reside at the facility may be affected by alleged deficient practice.The Maintenance Director has inspected the entire building for use of other extension cords. All extension cords have been removed.The Maintenance Director inspected all junction boxes to ensure they were covered properly. What measures will be put into place or what systemic changes you will</p>	12/20/2013			

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	<p>wiring in 3 of 7 smoke compartments. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 20 or more residents in the north, east and west smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/13 between 10:00 a.m. and 2:00 p.m., a power strip extension cord supplied power to a microwave in the physical therapy storage closet, medicine dispensing equipment in the east medicine room, and decorative lighting and a refrigerator in resident room 206. In addition, a power strip and extension cord were piggybacked in the MDS office to provide power to office equipment. The maintenance director said at the time of observations, the power strips and extension cord were not approved for use.</p> <p>3.1-19(b)</p>		<p>make to ensure that the deficient practice does not recur All staff was educated on 12/10/2013 by Executive Director that the use of extension cords in the facility is not permitted. The Maintenance Director will inspect the junction boxes to ensure they continue to be covered properly. The Maintenance Director will monitor building for no usage of extension cords.</p>		