

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2015
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NAME OF PROVIDER OR SUPPLIER WARSAW MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN 46580
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K 000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/06/2015</p> <p>Facility Number: 000359 Provider Number: 155566 AIM Number: 100274920</p> <p>At this Life Safety Code survey, Warsaw Meadows 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 III (211) construction in the original building and Type V (111) construction in the northwest, west and laundry wings and all were fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors and battery operated smoke detectors in</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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K 022 SS=D Bldg. 01	<p>the resident rooms. The facility has a capacity of 80 and had a census of 69 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a detached garage providing storage for the mowers and maintenance supplies, a shed with activity supplies, and a storage pod with wheelchairs, beds and walkers.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 1 of 4 doors likely to be mistaken for a way of exit from the Harmony Hall was identified as "No Exit". LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads: NO Exit. This deficient practice could</p>	K 022	<p>This plan of correction is to serve as Warsaw Meadows Care Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Warsaw Meadows Care Center or its' management company that the allegations contained in this survey report are a true and accurate portrayal of the provisions of nursing care and other services in this facility. Nor does this submission constitute agreement or admission of the survey allegations.</p>	05/06/2015

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K 025 SS=F Bldg. 01	<p>affect 14 residents in Harmony Hall.</p> <p>Findings include: Based on observation with the Maintenance Director on 04/06/2015 at 12:35 p.m., the door leading to an enclosed court yard containing the residents smoking area lacked a sign that identified the door either as an exit or not an exit. Based on interview at the time of observation, the Maintenance Director acknowledged the door was not identified either way.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may</p>		<p>We are respectfully requesting we be considered for a paper compliance resolution to this survey event.</p> <p>K 022 Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants.</p> <p>I. A door on Harmony Hall was not marked "NO EXIT".</p> <p>II. This alleged deficiency could affect the 14 residents on Harmony Hall.</p> <p>III. A new sign reading "NO EXIT" was ordered on 4/6/15.</p> <p>IV. The Director of Maintenance is required to review all areas of egress and non egress doors quarterly as part of his preventative maintenance package. The results of these reviews will be included as part of our Quality Improvement Process Meeting quarterly moving forward. Any recommendations for change in signage will be directed to the Administrator and acted on as needed immediately.</p> <p>V. Date of compliance 5/6/15.</p>		

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	<p>terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel 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. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 3 smoke barrier walls was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect two of three smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with Maintenance Director on 04/06/2015 at 1:02 p.m. the water softener room smoke barrier wall had an unsealed penetration. Where the</p>	K 025	<p>K 025 Smoke barriers are constructed to provide at least one half 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 and steel frames. A minimum of two separate compartments are provided on each door. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems.</p> <p>I. Recent work on the facility's piping systems left minor holes between smoke barrier walls.</p> <p>II. This alleged deficiency could affect all residents in the event of a fire.</p> <p>III. All holes have been caulked and sealed.</p> <p>IV. The Director of Maintenance is responsible for ensuring the integrity of our three smoke barriers. He also schedules all contractors that may need to run wiring, piping, etc. through those barriers. A checklist has been created as an audit tool for fire</p>	05/06/2015			

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K 038	<p>ceiling and wall meet there was an unsealed penetration which was a one inch hole with a one quarter inch gap to allow a water line to pass through to the next room. The power cord to the water heater also ran through the wall causing a one eight inch gap. Based on interview, both penetrations were acknowledged by the Maintenance Director at the time of observations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect two of three smoke compartments.</p> <p>Findings include:</p> <p>Based on observations and interview on 04/06/2015 at 1:51 p.m., the Maintenance Director acknowledged the two inch unsealed ceiling penetration in the laundry room closet where the roof had leaked.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		<p>prevention and safety that includes monitoring those smoke barriers monthly and bringing the results of those findings to the quarterly Quality Improvement Process Meeting. In addition, any loss of integrity to those three barriers will be addressed as soon as the contractors leave and will be inspected by the Administrator.</p> <p>V. Date of compliance 5/6/15.</p>				

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SS=E Bldg. 01	<p>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>Based on observation and interview, the facility failed to ensure 1 of 6 exit access corridors was readily accessible and unobstructed at all times. This deficient practice could affect any of the 45 residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on an observation during the tour of the facility with the Maintenance Director on 04/06/2015 at 1:52 p.m. the following items were being stored in the Center Hall North Laundry exit corridor: two chairs, three dollies, snow shovel with salt and miscellaneous storage.</p> <p>Based on an interview at the time of observation, the Maintenance Director acknowledged these items were being stored in the corridor and were only supposed to be in the corridor when they are in use.</p> <p>3.1-19(b)</p>	K 038	<p>K038 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1.</p> <p>I. The hallway between Therapy and Activities/Laundry Services had items stored along one wall that needed serviced.</p> <p>II. This alleged deficiency could affect any resident needing to evacuate through the back door of that hallway.</p> <p>III. All staff were in-serviced on 4/8/15 pertaining to keeping hallways free of any items that are not in use (example used from Federal guideline, if any item is not going to be used for more than two hours it must be stored in an appropriate spot and not be left in hallways). The items were removed.</p> <p>IV. The Maintenance Director will ensure daily that items are not stored in hallways as part of his daily rounds. In addition, the Administrator will follow up with any items found in hallways and designate their placement. A hallway audit has been added to the Maintenance Director's daily walk through tool and the Weekend Manager Log.</p> <p>V. Date of compliance 5/6/15.</p>	05/06/2015	
K 048	NFPA 101				

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SS=D Bldg. 01	<p>LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>Based on record review and interview, the facility failed to provide a written plan that included the evacuation of smoke compartments in the facility 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:</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 affect all occupants.</p> <p>Findings include:</p> <p>Based on a record review and interview on 04/06/15 at 11:55 a.m., the Maintenance Director acknowledged the "Disaster Plan" did not address their kitchen K class extinguisher nor did it include response to battery operated smoke alarms.</p>	K 048	<p>K 048 There is a written plan for the protection of all patients and for their evacuation in the event of an emergency</p> <p>I. The Disaster Plan did not have specific requirements for addressing the battery operated smoke detectors in resident's rooms nor the K class extinguishers in the kitchen.</p> <p>II. This alleged deficiency could affect all residents.</p> <p>III. The Disaster Plan was updated to include instructions for monitoring, replacing, and responding to the battery operated smoke detectors and the manufacture's instructions for use of the K class extinguishers was added.</p> <p>IV. The Administrator is required to review all policies and procedures annually to ensure correctness and completeness. Changes required due to changes in law or State policies will be included as they are sent to the facility and will be signed off on annually by the Administrator, dept heads, and the Medical Director.</p> <p>V. Date of compliance 5/6/15.</p>	05/06/2015
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K 062 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained in proper working order. Once obstructive material is observed during an investigation as described in NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems at 10-2.1., NFPA 25, 10-2.3 requires a complete flushing program shall be conducted. The work shall be done by qualified personnel. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 04/06/2015 at 12:04 p.m., the "Report of Inspection" from the SafeCare 's interior pipe inspection on the sprinkler systems stated "Recommend that system be flushed! "</p>	K 062	<p>K 062 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.</p> <p>I. The required 5 year flush of the dry system was not completed. 10 sprinkler heads were found to have some form of corrosion on them.</p> <p>II. This alleged deficiency could affect all residents.</p> <p>III. Qualified personnel have been contracted to complete a flush of the system and replace each of the identified sprinkler heads found deficient. Contractors have completed letters for State review of when they will be completing both of these operations.</p> <p>IV. The Director of Maintenance is responsible for ensuring fire systems are up to date and operating accordingly. Inspections by SafeCare and the local fire department that result in</p>	05/06/2015	

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	<p>Based on an interview with the Maintenance Director at the time of record review, there has not been a system flush.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 10 of 250 sprinkler heads in the building. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 24 Memory Lane residents and facility staff.</p> <p>Findings include:</p> <p>Based on observation during a tour with the Maintenance Director on 04/06/15 at 12:57 p.m. to 2:36 p.m., the following was noted:</p> <p>a) One of twelve automatic sprinklers in Memory Lane Hall was corroded with a green substance.</p> <p>b) One of one automatic sprinkler heads in the Center Hall - North Storage room</p>		<p>any suggestions or concerns will be acted on immediately. Sprinkler head reviews have been added to the daily walk through auditing tool and recommendations from the Maintenance Director will be addressed by the Administrator upon receipt. A review of all safety systems is included in the quarterly Quality Improvement Process Meeting and recommendations made at that time will also be addressed immediately.</p> <p>V. Date of Compliance: 5/6/15</p>	

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	<p>was covered in white paint.</p> <p>c) Five of ten automatic sprinklers in the Laundry room were corroded with a green substance.</p> <p>d) Two of six automatic sprinklers in the Kitchen were corroded with a grease and lint.</p> <p>e) One of one automatic sprinkler in the Kitchen dish machine room was corroded. Based on interview at the time of observations, the Maintenance Director acknowledged the condition of the sprinkler heads.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 Pantry room sprinklers in the facility was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could affect staff</p>			

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K 066 SS=D Bldg. 01	<p>only.</p> <p>Findings include:</p> <p>Based on observation and interview during a tour on 04/06/15 at 2:32 p.m., the Maintenance Director acknowledged the distance between a case of bowls was less than 3 inches of distance to the sprinkler head in the Kitchen pantry.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover</p>				

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	<p>devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 areas where smoking was permitted for staff and residents were maintained and the metal container with a self-closing cover was used for an ashtray. This deficient practice could affect residents and facility staff who smoke cigarettes at the main entrance smoking area.</p> <p>Findings include:</p> <p>Based on observations and interview on 04/06/2015 at 2:40 p.m., the Maintenance Director acknowledged there were at least 36 cigarette butts on the ground in the designated resident and staff main entrance smoking area. This area was provided with a "smoker 's oasis" which is a metal container with a long neck used for cigarette butts.</p> <p>3.1-19(b)</p>	K 066	<p>K 066 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 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 with ashtrays can be emptied are readily available to all areas where smoking is permitted.</p> <p>I. Cigarette butts were found in the resident's smoking area (two) and at the front entrance (36) where a huge snow pile had melted from having the parking lot plowed. In both areas the correct ashtray devices are available.</p> <p>II. This alleged deficient practice could affect all residents and staff that smoke.</p> <p>III. Staff that take residents out to the designated smoking area are responsible for</p>	05/06/2015	

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K 069 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to protect cooking equipment with a range hood extinguishing system in accordance with LSC Sections 9.2.3 and 19.3.2.6 and NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations in 1 of 1 Activity room cooking area. NFPA 96, 7-1.2 requires cooking equipment that	K 069	ensuring all cigarette butts are placed in the correct device and that none are left on the ground. Cigarette safety and the placement of our receptacles was covered in the All Staff on 4/8/15, including the one at the front entrance. IV. All staff members are responsible for the upkeep of this facility and are required to be responsible in their habits. The Maintenance Director will review the area out each door that could have cigarette butts left and clean them up as part of his daily rounds. This item has been added to his daily walk through checklist and results will be reported quarterly at the Quality Improvement Process Meeting. Devices will be added as necessary. V. Date of completion: 5/6/15. K 069 Cooking facilities are protected in accordance with 9.2.3. I. The Activity Room had cooking devices in violation of facility policy as well as State policy. II. All residents using the Activity Room could be affected. III. All cooking devices have been removed from the Activity Department and any cooking required will be completed	05/06/2015

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K 070	<p>produces grease laden vapors (such as but not limited to deep fat fryers, ranges, griddles, broilers, woks, tilting skillets, and braising pans) shall be protected by fire extinguishing equipment. This deficient practice could affect any resident, as well as staff and visitors using the Activity room cooking area.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/06/2015 at 1:38 p.m., an electric skillet was discovered in the Activity Room. Based on interview during the time of observation with the Life Enrichment Assistant, she remarked the electric skillet in the Activity Room cooking area was used for frying foods containing animal fats. Based on interview at the time of observation, the Maintenance Director acknowledged the electric skillet in the Activity Room cooking area lacked a hood extinguishing system.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		<p>in the kitchen under supervision using the correct devices. The Activity Department completed an in-service on 4/27/15 to ensure they are all aware of the policy and risks involved in such activities.</p> <p>IV. The Administrator is responsible for all areas of the facility and will ensure policies are being adhered to. The Administrator will be aware of planned activities and anything involving cooking of any kind will be monitored by him. As part of the quarterly Quality Improvement Process Meeting activities will discuss and document all events (calendar) and will make the Interdisciplinary Team aware of cooking needs prior to the upcoming events so the Administrator will be available to monitor.</p> <p>V. Date of Compliance: 5/6/15.</p>		

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SS=E Bldg. 01	<p>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) 19.7.8</p> <p>Based on observation and record review, the facility failed to enforce the policy for the use of 1 of 1 portable space heaters in the facility in accordance with NFPA 101, Section 19.7.8. This deficient practice is not in a resident care area but could affect any number of staff.</p> <p>Findings include:</p> <p>a. Based on observation with Maintenance Director on 04/06//2015 at 12:03 p.m., in the Marketing Office, two space heaters were discovered on the floor. Based on interview at the time of observation with the Maintenance Director, he was unable to provide documentation to confirm the two space heaters element did not exceed 212 degrees (100 degrees C).</p> <p>b. Based on observation with Maintenance Director on 04/06//2015 at 2:44 p.m., in the Marketing office, one open coil space heaters was discovered on the floor. Based on interview at the time of observation, the Maintenance Director confirmed the heating element exceeded 212 via a temperature probe.</p>	K 070	<p>K 070 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.</p> <p>I. The Community Liaison office had a space heater in it that exceeded 212F when on full blast.</p> <p>II. No residents could be affected by this deficiency.</p> <p>III. The facility owns 12 space heaters that fit all the guidelines of their own policy and State requirements. They also have all of the necessary documentation. Any space heater found that is not one of ours was removed permanently.</p> <p>IV. Staff were in-serviced on 4/8/15 on the use of space heaters and the policy for their use. This policy will be part of All Staff meetings twice a year and the entire staff will sign for their acknowledgement of the requirements.</p> <p>V. Date of compliance: 6/5/15.</p>	05/06/2015

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K 075 SS=D Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area which was not protected as a hazardous area for 1 of 58 resident rooms. This deficient practice could affect at least 10 residents as well as staff and visitors on the Cedars wing center hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/06/2015 at 2:11 p.m., one 32 gallon container of biohazardous soiled linen and one 32 gallon container of biohazardous trash were adjacent to one another in resident room 56. Based on an interview at the</p>	K 075	<p>K 075 Soiled linen or trash collection receptacles do not exceed 32 gallons in capacity. A capacity of 32 gallons is not exceeded within any 64 sq ft area. Mobile soiled linen or trash collection receptacles with capabilities greater than 32 gallons are located in a room protected as a hazardous area when not attended.</p> <p>I. A resident with isolation precautions had a "double barrel" for hazardous materials that each compartment had a 32 gallon bag in.</p> <p>II. Residents under isolation due to a transferrable disease could be affected.</p> <p>III. The double barrel was removed and disposed of. Replaced with 15 gallon variety.</p> <p>IV. That was the only barrel of that type in the facility and no other ones will ever be ordered.</p>	05/06/2015

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K 130 SS=F Bldg. 01	<p>time of observation, the Maintenance Director confirmed the containers were used for biohazardous waste and linen.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation and interview, the facility failed to ensure the penetration in 1 of 2 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the</p>	K 130	<p>Central Supply has a listing of items on the "DO NOT ORDER" roster. The double barrel bag holders have been included.</p> <p>V. Date of compliance: 6/5/15.</p> <p>K130 Other LSC deficiency not on 2786.</p> <p>I. Small openings were found in smoke barrier walls due to recent contract work.</p> <p>II. All residents could be affected by the holes in the smoke barrier.</p> <p>III. The Maintenance Director has repaired all of the holes found during survey.</p> <p>IV. The Maintenance Director has instructions of management of contractors and a checklist for following up with repairs needed upon their exit. All preventative maintenance, inspections, checklists, and required audits are compiled as part of monthly Process Improvement meetings and reviewed for trends in the quarterly Quality Improvement Meeting.</p> <p>V. Date of Completion: 5/6/15</p>	05/06/2015			

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	<p>sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect residents in 2 of 3 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 04/07/2015 at 2:54 p.m., there were five penetrations of water lines, conduit, and gas lines passing through the fire wall ranging sizes from 1/4" to 5". This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the penetration in 1 of 2 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring</p>			

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	<p>the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect residents in 2 of 3 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 04/07/2015 at</p>			

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K 143 SS=D Bldg. 01	<p>3:13 p.m., two unsealed one inch penetrations of conduit and wires were discovered passing through the attic fire barrier wall near the boiler room. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <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 2 of 2 liquid oxygen containers used for transferring of oxygen were stored in an area provided with continuous mechanical ventilation. This deficient practice could affect at least 10 residents in 1 of 3 smoke compartments.</p> <p>Findings include:</p>	K 143	<p>K 143 NFPA 101 Life Safety Code Standard</p> <p>I. Two portable O2 tanks were found in a clean utility room instead of the O2 room.</p> <p>II. All residents could be affected by deficiency.</p> <p>III. Employees were in-serviced on 4/8/15 during All Staff on proper storage of O2 tanks.</p>	05/06/2015

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K 144 SS=F Bldg. 01	<p>Based on an observation with the Maintenance Director on 04/06/2015 at 2:13 p.m., two liquid oxygen containers where stored in the Clean Utility room which lacked continuous mechanical ventilation. At the time of observation, the Maintenance Director confirmed the two liquid oxygen containers should be in the Oxygen Storage Supply room which did have the proper ventilation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. In addition, NFPA 101 at Section 4.6.12.1 requires that any device, equipment or system required for compliance with this Code shall be continuously maintained. This deficient practice could affect all occupants in the</p>	K 144	<p>IV. O2 tank storage was added to the daily walk through checklist for the Maintenance Director to complete. Any discrepancies are to be corrected immediately. Findings of the checklist are included in monthly Process Improvement Meeting and trended during quarterly Quality Improvement Process Meeting.</p> <p>V. Date of Completion: 6/5/15</p> <p>K144 NFPA 101 Life Safety Code Standard</p> <p>I. Enunciator light was burned out the day surveyors came. II. This deficiency would not affect any residents. III. Fuse was replaced 4/6/15. Fuse did not affect operation of the generator and was not burned out during the last load test. IV. The Maintenance Director is responsible for load testing and that all equipment is operational during these tests. Any other fuse that may burn out will be</p>	04/06/2015	

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K 147 SS=D Bldg. 01	<p>facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on an observation with Maintenance Director on 04/06/2015 at 12:41 p.m., when the test button was pressed, the generator annunciator panel at the nurse's station failed to provide an audio or visual alarm. Based on an interview with the Maintenance Director at the time of observation, he acknowledged that no lights or sounds occurred when the test button was pressed.</p> <p>3-1.19(b)</p> <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>Based on observation and interview, the facility failed to ensure 3 of 3 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</p>	K 147	<p>replaced immediately.</p> <p>V. Date of Completion: 4/6/15.</p> <p>K147 Electrical wiring and equipment in accordance with NFPA 70, National Electrical Code 9.1.2.</p> <p>I. The Maintenance Office had a power strip installed years ago onto the wall that fed the security system. He also had coffee pots and a pencil sharpener plugged</p>	05/06/2015			

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	<p>cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>a. Based on observation with Maintenance Director on 04/06/2015 at 1:09 p.m. in the Maintenance office, a power strip was plugged into a power strip then used to power a refrigerator and security equipment. Based on interview at the time of observation with the Maintenance Director, he acknowledged and removed the refrigerator.</p> <p>b. Based on observation with Maintenance Director on 04/06/2015 at 1:38 p.m. in the Activities room, a power strip was used to power two coffee pots, a radio, and a pencil sharpener. Based on interview at the time of observation with the Maintenance Director, he acknowledged the deficiency.</p> <p>c. Based on observation with Maintenance Director on 04/06/2015 at 2:01 p.m. in the Employee Lounge in Center Hall - South, a power strip was used to power a microwave and a toaster. Based on interview at the time of observation with the Maintenance Director, he acknowledged the deficiency.</p> <p>3.1-19(b)</p>		<p>into a power strip instead of the wall.</p> <p>II. This deficiency could affect residents if an electrical fire started.</p> <p>III. A qualified electrician removed the power strip on the wall and created an approved circuit to the security system that is hard wired into the fuse box. Power strips were removed from all offices.</p> <p>IV. Power strips were added to the daily walk through checklist. Any observed will be removed. If there is a need for more outlets it will be brought to the Administrator's attention and acted on immediately.</p> <p>V. Date of Completion: 5/6/15</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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