

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155156	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2012
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NAME OF PROVIDER OR SUPPLIER ARBORS AT MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/05/12</p> <p>Facility Number: 000076 Provider Number: 155156 AIM Number: 100271060</p> <p>Surveyors: Dennis Austill, Life Safety Code Supervisor, Robert Sutton, Life Safety Code Specialist Trainee</p> <p>At this Life Safety Code survey, Arbors at Michigan City 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 facility is a one story building determined to be of Type V (111) construction was partially sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces</p>	K0000	<p>The submission of this plan of correction does not indicate an admission by The Arbors of Michigan City that the findings and allegations contained here in are accurate and true representations of the quality of care and services provided to the residents of The Arbors of Michigan City. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility here by maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirement governing the management of this facility. It is submitted as a matter of stature only.</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>open to the corridors and hardwired smoke detectors in all 115 resident rooms. The facility has a capacity of 180 and had a census of 159 at the time of this visit.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage and in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where the residents have customary access were not sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/10/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0014 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure materials used as an interior finish in the corridor had a flame spread rating of Class A or Class B in order to protect 30 of 159 residents. LSC 101, 10.2.3.2 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development.</p> <p>(a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire.</p> <p>(b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test</p>	K0014	<p>1. On 09/10/12, obtained siding flame spread classification from the manufacturer's web site.</p> <p>2. We reviewed all related information to ensure we had all documentation of flame spread classification.</p> <p>3. All related information will be presented monthly at the safety portion of the QAA meeting.</p> <p>4. Plant Ops Supervisor will bring information to the monthly Safety Committee and QAA Meeting.</p>	10/05/2012

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	<p>scale.</p> <p>(c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect any resident on the 100 wing as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Services during a tour of the facility on 09/05/12 at 10:35 a.m., the 100 wing porch had vinyl siding used as an interior finish. Interview with the Director of Plant Services at the time of observation indicated no documentation was available to demonstrate the siding exhibited a flame spread classification of Class A or B.</p> <p>3.1-19(b)</p>				

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K0017 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 areas were separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or meet an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by automatic sprinklers, or the furnishings and furniture, in combination with all other combustibles within the area, are of such minimum quantity and</p>	K0017	<p>1.Plant Op's Supervisor is securing bids to add and move smoke detectors and sprinkler heads to be in compliance with the current code. After receiving bids, work will be approved and scheduled and completed.</p> <p>2.Plant Op's Supervisor will include measuring the distance and the need for smoke detectors whenever a construction project is needed.</p> <p>3.Plant Op's will include on monthly safety checklist.</p> <p>4.Plant Op's Supervisor will bring information to the monthly Safety Committee and QAA Meeting</p>	10/12/2012			

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	<p>arrangement that a fully fully developed fire is unlikely to occur and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect any resident, staff or visitor in the vicinity of the front business office.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Services during a tour of the facility at 11:10 a.m. on 09/05/12, the front business office had a sliding glass window separating the room from the corridor. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because the front business office was not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of observation, the Director of Plant Services acknowledged the front business office was not protected by an electrically supervised smoke detection system.</p> <p>3.1-19(b)</p>			
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K0029 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 3 of 12 doors serving hazardous areas such as kitchens and laundry/gas fired heater rooms closed and latched to prevent the passage of smoke. This deficient practice could affect all residents, visitors and staff in the facility.</p> <p>Findings include:</p> <p>a. Based on observation with the Director of Plant Services during a tour of the facility at 11:05 a.m. on 09/05/12, the two kitchen doors used for entering and exiting the kitchen from the main dining room did not self close and latch into the frame. Based on interview during the time of observation, the Director of Plant Services acknowledged the kitchen doors did not self close and latch into the door frames.</p>	K0029	<p>1. On 09/18/12 Plant Op's Supervisor adjusted doors that had been caught on carpet. The doors had self closing hinges that latch into the frames.</p> <p>2. On 9/19/2012, the kitchen doors have been adjusted to close and latch.</p> <p>3. Plant Op's personnel will check all doors on a monthly basis. Dietary Manager or designee will do a check on doors on a weekly basis.</p> <p>4. Plant Op's Supervisor will bring information to the monthly Safety Committee and QAA Meeting</p>	10/05/2012			

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	<p>b. Based on observation with the Director of Plant Services during a tour of the facility at 1:30 p.m. on 09/05/12, the mechanical room behind the laundry contained a gas fired water heater and the corridor door to this room lacked a door closer. Based on interview during the time of observation, the Director of Plant Services acknowledged the laundry dryer/gas fired water heater access door did not have a self closer to ensure the door closed and latched into the door frame.</p> <p>3.1-19(b)</p>			

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K0038 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation, the facility failed to ensure 26 of 26 exit door electromagnetic locks remained unlocked while the fire alarm was activated. Note: Life Safety Code (LSC) 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6(a) requires doors with special locking arrangements such as electromagnetic locks to unlock upon actuation of an approved fire alarm system installed in accordance with LSC 9.6. LSC 9.6.1.4 requires a fire alarm system to be installed, tested and maintained in accordance with NFPA 72, the National Fire Alarm Code. NFPA 72, 3-9.7.2 requires that all emergency exits connected to the fire alarm system unlock upon receipt of any fire alarm signal by the fire alarm system serving the protected premises.</p> <p>Findings include:</p> <p>Based on observation on 09/05/12 at 2:15 p.m. with the Director of Plant Services, the fire alarm system was activated by a pull station near the 300 northeast exit and the magnetically locked door released</p>	K0038	<p>1.Fire Alarm Company is scheduled to repair the system controls so that doors can remain unlocked while the alarm system is silenced.</p> <p>2.All doors will be checked during the fire drills for proper operation 3'xs per quarter</p> <p>3.Continued monitoring of activation and deactivation will continue and be documented by the Plant Ops department.</p> <p>4.Plant Ops Supervisor will bring information to the monthly Safety Committee and QAA Meeting</p> <p>1.Stickers stating the doors can be opened in 15 seconds were placed on doors on 09/06/12</p> <p>2.All other doors inspected for deficiency by Plant Ops Supervisor</p> <p>3.Monthly door inspections will be completed by Plant Ops personnel on an ongoing basis.</p> <p>4.Plant Ops Supervisor will bring information to the monthly Safety Committee and QAA Meeting.</p>	10/05/2012			

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	<p>but relocked when the fire alarm was silenced. Additional exit doors in the vicinity were checked and found to be magnetically relocked as well. Based on interview during the time of observation, the Director of Plant Services acknowledged the magnetically locked exit doors relocked when the fire alarm system was silenced but not reset.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the means of egress through 2 of 26 delayed-egress locks was readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that:</p> <p>(a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke</p>			

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	<p>detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6.</p> <p>(b) The doors unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS</p> <p>This deficient practice could affect 40 of 159 residents, staff and visitors on the 200 west and 300 east wings of the facility.</p> <p>Findings include:</p>			

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	<p>Based on observation on 09/05/12 between 12:45 p.m. and 1:30 p.m. with the Director of Plant Services, the set of 200 west wing exit doors and the 300 east exit door lacked signage detailing the 15 second delay in opening the exit doors. Based on interview during the time of observation, the Director of Plant Services acknowledged the exit doors lacked 15 second delay signage because the exit doors were recently replaced.</p> <p>3.1-19(b)</p>				

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K0046 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 battery operated emergency lights were tested annually in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect any occupant in the facility including staff, visitors and residents if the facility were required to evacuate in an emergency during a loss of normal power.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Services on 09/05/12 at 12:25 p.m., there were two battery operated emergency light packs in the facility. One light was at the generator transfer switch in the boiler room and the other above the exit leading to the emergency generator</p>	K0046	<p>1.On 09/07/12 obtained LSC battery-back up lighting check procedure and form, 2.LSC form and 90 min test completed on 09/11/12 3.Plant Ops personnel will complete monthly checks and a 90 minute annual check on all battery backup lighting to ensure it functioning correctly. 4.Plant Ops Supervisor will bring information to the monthly Safety Committee and QAA Meeting</p>	10/05/2012			

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	location. Based on interview during the time of observation, the Maintenance Supervisor acknowledged there was no documentation of monthly testing or an annual 90 minute test for the battery operated emergency lights in the facility. 3.1-19(b)			

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K0050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to insure fire drills included the transmission of a fire alarm signal in 8 of 12 fire drills conducted between 6:00 a.m. and 9:00 p.m. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Fire/Disaster Drill Records" with the Director of Plant Services at 11:30 a.m. on 09/05/12, the documentation for the fire drills</p>	K0050	<p>1. On 09/09/12 obtained LSC version of fire drill records. On 09/10/12, we tested smoke detector. DPO contacted monitoring system, asked for confirmation and received fax confirming call was received.</p> <p>2. A detailed fire drill record will be kept with confirmation of receipt of alarm to our monitoring station.</p> <p>3. Plant Op's Supervisor will monitor Fire Drill forms for confirmation on a monthly basis.</p> <p>4. Plant Ops Supervisor will bring information to the monthly Safety Committee and QAA Meeting</p>	10/05/2012			

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	<p>performed on the first and second shifts did not indicate the fire alarm system had been activated. Based on interview at the time of observation, the Director of Plant Services acknowledged the fire drill record form did not document the activation of the fire alarm system or transmission of the fire alarm signal.</p> <p>3.1-19(b) 3.1-51(c)</p>			

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K0051 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 11 of 240 smoke detectors connected to the fire alarm system were properly separated from an air supply. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect residents, staff, and visitors throughout the facility.</p> <p>Findings include: Based on observations with the Director</p>	K0051	<p>1.Plant Op's Supervisor is securing bids to add and move smoke detectors and sprinkler heads to be in compliance with the current code. After receiving bids, work will be approved and completed.</p> <p>2.Plant Op's Supervisor will include measuring the distance and the need for smoke detectors whenever a construction project is needed.</p> <p>3.Plant Op's Supervisor will add checking distances of smoke detectors on his monthly check list.</p> <p>4.Plant Op's Supervisor will bring information to the monthly Safety Committee and QAA Meeting</p>	10/12/2012			

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	<p>of Plant Services on 09/05/12 during the tour from 10:30 a.m. and 215 p.m., the following was noted:</p> <p>a. Two smoke detectors located in the 100 wing common area in front of the nurses' station were less than 36 inches from an air vent.</p> <p>b. One smoke detector located in the 100 wing corridor in front of the restroom was less than 36 inches from an air vent.</p> <p>c. One smoke detector located in the 400 wing corridor near the north nurses' station was less than 36 inches from an air vent.</p> <p>d. Two smoke detectors located in the 400 wing common area in front of the nurses' station were less than 36 inches from an air vent.</p> <p>e. One smoke detector located in the 400 wing janitor's closet was less than 36 inches from an air vent.</p> <p>f. One smoke detector located in the 400 wing pantry was less than 36 inches from an air vent.</p> <p>g. Three smoke detectors located in the common area in front of the 300 wing nurses' station were less than 36 inches from an air vent.</p> <p>The Director of Plant Services confirmed the distances between the vents or fans and agreed the air flow could interfere with smoke detector function.</p> <p>3.1-19(b)</p>			

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K0054 SS=F	<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 100 % of smoke detectors had been sensitivity tested. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72 at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <p>(1) Calibrated test method. (2) Manufacturer's calibrated sensitivity</p>	K0054	<p>1.Fire Safety Company scheduled to inspect in month of September 2.Quarterly inspections are in agreement with sensitivity test every 2 years for the 6 duct detectors. 3.Testing will be completed per agreement and verified by DPO 4.Plant Ops Supervisor will bring information to the monthly Safety Committee and QAA Meeting</p>	10/05/2012			

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	<p>test instrument.</p> <p>(3) Listed control equipment arranged for the purpose.</p> <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range.</p> <p>(5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector." This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on review of "Smoke Detector Sensitivity Test" dated 04/27/2011 on 09/05/12 during record review at 9:45 a.m., the test report did not include results for six duct detectors identified on the "Periodic Fire Alarm Inspection & Test Report" dated 07/24/2012. Based on interview at 11:30 a.m., the Director of Plant Services acknowledged the duct detectors were not included in the documentation.</p>						

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	3.1-19(b)			

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K0056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to provide sprinkler protection in all combustibile structures residents use in accordance with LSC Section 19.1.6.2 and NFPA 13, 1999 Edition. This deficient practice could affect 2 of 159 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Services on 09/05/12 at 1:00 p.m., the resident smoking building, a separate, detached building of Type V (000) construction lacked sprinkler protection. Based on interview at the time of observation, the Director of Plant Operations acknowledged there are two residents who smoke and use the nonsprinklered smoking building.</p>	K0056	<p>1.09/17/12 Plant Op's Supervisor has secured outside building so that there is no access to enter by residents.</p> <p>2. Discussion with current residents took place about the building is not longer being accessible.</p> <p>3. Shower curtains have been replaced with mesh top curtain.</p> <p>4. Plant Ops Supervisor will bring information to the monthly Safety Committee and QAA Meeting</p> <p>1. Plant Op's Supervisor is securing bids to add and move smoke detectors and sprinkler heads to be in compliance with the current code for canopies. After receiving bids, work will be approved and completed.</p> <p>2. Plant Op's Supervisor will include measuring the distance and the need for smoke detectors</p>	10/12/2012	

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	<p>3.1-19(b) 3.1-19(ff)</p> <p>2. Based on observation and interview, the facility failed to provide sprinkler coverage for 2 of 3 combustible exterior canopies which were wider than 4 feet. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width. Section 5-13.8.2 requires sprinklers shall be installed under roofs or canopies over areas where combustibles are stored and handled. This deficient practice could affect residents, staff and visitors using the main entrance.</p> <p>Findings include:</p> <p>a. Based on observation with the Director of Plant Services on 09/05/12 at 12:25 p.m., the canopy of wood construction outside of the water softener/boiler room was not provided with sprinkler protection. The wood construction canopy was not directly attached to the building but extended six inches above the roof and over 4 feet from the building. Combustible material located under the canopy included the facility of Type V (111) construction and a six foot portion</p>		<p>whenever a construction project is needed and add that to the checklist.</p> <p>3. Housekeeping Supervisor has curtains on the monthly checklist to monitor if curtain is compliant to code.</p> <p>4. Plant Op's Supervisor and Housekeeping Supervisor will bring information to the monthly Safety Committee and QAA Meeting</p>				

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	<p>of a wooden fence. Based on interview at the time of observation, the Director of Plant Services acknowledged the canopy was not provided with sprinkler protection.</p> <p>b. Based on observation with the Director of Plant Services on 09/05/12 at 1:40 p.m., the canopy of canvas construction over a metal frame outside of the 400 wing main entrance was not provided with sprinkler protection. The canvas canopy was attached to the building and extended over four feet from the building. Based on interview at the time of observation, the Director of Plant Services acknowledged the facility did not have documentation available for review to verify the canvas material was inherently flame retardant and it was not provided with sprinkler protection.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>3. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Edition, Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, Section 5-6.3.4, "Minimum Distance between Sprinklers", states sprinklers shall be spaced not less than 6 feet on</p>			

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	<p>center. In addition, LSC 19.1.1.4.5 requires minor renovations, alterations, modernizations, or repairs shall not reduce life safety below the level that previously existed. This deficient practice could affect residents, staff or visitors throughout the facility.</p> <p>Findings include:</p> <p>Based on observations with the Director of Plant Services on 09/05/12 during the tour from 10:30 a.m. and 2:15 p.m., the following was noted:</p> <ul style="list-style-type: none"> a. Two sprinklers in the 100 east dining room above the dishwasher were four feet apart. b. Two sprinklers in the Assistant Executive Director's office were three feet apart. c. Three sprinklers in the vending room were less than six feet apart. d. Four sprinklers in Medical Records were four feet apart. e. Six sprinklers in Central Supply were four feet apart. f. Two sprinklers in the Therapy Gym restroom were five feet apart. <p>The Director of Plant Services confirmed the distances between the sprinkler heads and agreed the distance was less than six feet.</p> <p>3.1-19(b)</p>						

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	<p>3.1-19(ff)</p> <p>4. Based on observation and interview, the facility failed to ensure sprinklers in areas where cubicle curtains are installed were installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems in 1 of 4 shower rooms. This deficient practice could affect any resident or staff in the 400 wing shower room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Services on 09/05/12 at 1:35 p.m., the shower room is provided with sprinkler heads in each stall location and has cubicle curtains each hung from the ceiling without a 1/2 inch diagonal mesh or a 70 percent open weave top panel extending 18 inches below the sprinkler deflector. A center core area of the shower room was not provided with sprinkler protection with all the shower curtains pulled close. Based on interview at the time of observation, the Director of Plant Operations acknowledged when closed, the cubicle curtains in the shower room blocked the coverage of the sprinkler heads.</p> <p>3.1-19(b) 3.1-19(ff)</p>				

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K0064 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to inspect 36 of 36 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect all residents and staff in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observations with the Director of Plant Services on 09/05/12 during the tour from 10:30 a.m. and 215 p.m., the monthly inspection tag on fire extinguishers located in throughout the facility lacked documentation of a</p>	K0064	<p>1. Inspection was completed timely. Paperwork was not completed timely. This has been corrected. Inspections now up to date</p> <p>2. Plant Op's Supervisor implemented procedures to monitor future inspections.</p> <p>3. Checklist for documentation after inspection completed by Plant Op's Supervisor or Designee.</p> <p>4. Plant Ops Supervisor will bring information to the monthly Safety Committee and QAA Meeting</p>	10/05/2012			

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	<p>monthly inspection for August of 2012. This was acknowledged by the Director of Plant Services at the time of observation.</p> <p>3.1-19(b)</p>			

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K0066 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure trash and cigarette butts in 1 of 1 areas where smoking was permitted for residents staff were not commingled. This deficient practice could affect resident using the smoking area.</p> <p>Findings include:</p> <p>Based on observation on 09/05/12 at 1:05 p.m. with the Director of Plant Services, a trash container contained cigarette butts commingled with the paper trash. Based on interview at the time of observation,</p>	K0066	<p>1.Plant Op's Supervisor and Housekeeping Supervisor in-serviced staff and current residents who smoke on proper procedure for cleaning of cigarette material</p> <p>2.Removed trash cans from resident area. The procedure is to pick cigarette butts up and place in metal ashtray container.</p> <p>3.Plant Op's personnel and Housekeeping personnel will continue to inspect. inspections will be completed on a daily basis.</p> <p>4. Plant Ops Supervisor will bring information to the monthly</p>	10/05/2012

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	<p>the Director of Plant Services acknowledged the commingled trash indicating the cigarette butts were what was swept up from the floor and put into the trash.</p> <p>3.1-19(b)</p>		Safety Committee and QAA Meeting	

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K0069 SS=B	<p>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 ensure the grease filters on 2 of 2 kitchen stove hoods was properly positioned to drain the grease into the containers. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1998 Edition, at 3.2.7 says grease filters requiring a specific orientation to drain grease shall be clearly so designated, or the hood shall be constructed so filters cannot be installed in the wrong orientation. This deficient practice could affect kitchen staff and any residents or visitors in the adjoining dining room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Services on 09/05/12 at 11:00 a.m., grease filter baffles in both kitchen stove hoods were installed horizontally to drain grease from the exhaust hood. Based on interview at the time of observation, the Director of Plant Services acknowledged the baffle grease filters were not installed in the correct orientation.</p> <p>3.1-19(b)</p>	K0069	<p>1. On 09/06/12 changed filters and installed them correctly. 2. On 09/06/12 Plant Op's Supervisor held an in-service for the dietary dept staff and maintenance staff on proper procedure for installation of hood vent filters 3. Dietary staff to clean weekly and replace correctly. Dietary Supervisor or designee will check the filters on a weekly basis and record on dietary sanitation checklist. 4. Plant Ops Supervisor and Dietary Supervisor will bring information to the monthly Safety Committee and QAA Meeting</p>	10/05/2012			

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K0154 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 159 of 159 residents in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Fire Watch policy and procedure with a review date of 5/2009 on 09/05/12 at 10:00 a.m., the fire watch procedure for an out of service automatic sprinkler system was not complete. The procedure stated, "It is the policy of this provider to implement a fire watch in case of emergency situations in which the fire suppression and/or the fire alarm system are out of service for a period of time longer than 4 hours." Based on interview at the time of review, the Director of Plant</p>	K0154	<p>1. On 09/13/12 downloaded LSC approved form and revised policy and procedure to specified wording, per L.S.C. section 9.6.1.8</p> <p>2. Plant Op's Supervisor placed Information on policy, procedure, and forms, with example in emergency and disaster manual.</p> <p>3. Inservice completed to make aware of policy change.</p> <p>4. Plant Ops Supervisor will bring information to the monthly Safety Committee and QAA Meeting</p>	10/05/2012			

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	<p>Services acknowledged the fire watch policy and procedure omitted the requirement for initiating a fire watch when the sprinkler system was out of service for 4 hours in a 24 hour period.</p> <p>3.1-19(b)</p>			

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K0155 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 159 of 159 residents in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Fire Watch policy and procedure with a review date of 5/2009 on 09/05/12 at 10:00 a.m., the fire watch procedure for an out of service automatic sprinkler system was not complete. The procedure stated, "It is the policy of this provider to implement a fire watch in case of emergency situations in which the fire suppression and/or the fire alarm system are out of service for a period of time longer than 4 hours. Based on interview at the time of review, the Director of Plant Services acknowledged the fire watch policy and procedure omitted the</p>	K0155	<p>1. On 09/13/12 downloaded LSC approved form and revised policy and procedure to specified wording, per L.S.C. section 9.6.1.8</p> <p>2. Plant Op's Supervisor placed Information on policy, procedure, and forms, with example in emergency and disaster manual.</p> <p>3. Inservice completed to make aware of policy change.</p> <p>4. Plant Ops Supervisor will bring information to the monthly Safety Committee and QAA Meeting</p>	10/05/2012			

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	<p>requirement for initiating a fire watch when the sprinkler system was out of service for 4 hours in a 24 hour period.</p> <p>3.1-19(b)</p>			