

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155685	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/02/2016
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELY AVE ELKHART, IN 46517
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Dates: 03/01/16 and 03/02/16</p> <p>Facility Number: 000039 Provider Number: 155685 AIM Number: 100275130</p> <p>At this Life Safety Code survey, Golden Living Center-Elkhart was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered except for the electrical room in the maintenance shop. The original building (North, East and South Units) was constructed in 1968 with an addition (Primrose and Southwest Units) built in 1975. The facility has a fire alarm system with smoke detection in the</p>	K 0000	Golden Living-Elkhart respectfully submit this response as the plan of correction for a Life Safety Code Survey completed on 3-2-16 We are alleging compliance as of 4-1-16	
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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 0018 SS=D Bldg. 01	<p>corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 175 and had a census of 152 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered with the exception of the electrical room in the maintenance shop. Quality Review completed on 03/10/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 110 resident room corridor doors closed and latched into the door frame. This deficient practice could affect 2 residents.</p>	K 0018	<p><b>It is the policy of this facility to ensure that resident room corridors close and latch into doorframes.</b></p> <p><b><u>Corrective Action taken for residents found to be affected by</u></b></p>	04/01/2016

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director on 03/01/16 at 2:11 p.m., the corridor door to resident room 418 was propped open with an over-the-bed table. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p><b><u>alleged deficient practice:</u></b></p> <ul style="list-style-type: none"> <li>- Over bed table was immediately removed, eliminating obstacle for room418, allowing the door to close securely into the door frame as per regulationrequirements.</li> <li>- <b><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></b></li> <li>- 100% audit of resident room doors completed to ensure no obstacles inplace and doors were latching into door frames.</li> </ul> <p><b><u>Measures put intoplace to ensure alleged deficient practice does not recur:</u></b></p> <p>Maintenance Director will complete morning and afternoon roundsthroughout building and will remove any obstacles found to be blocking residentroom doors to ensure that doors are free to latch into door frames.</p> <p>Maintenance Director will meet once a month with residents to go overregulation requirements regarding obstruction of room doors.</p> <p><b><u>How correctiveaction will be monitored to ensure alleged deficient practice does not recur:</u></b></p> <ul style="list-style-type: none"> <li>- Maintenance Director will meetwith ED 1 time a week to review audit records to identify and address</li> </ul>		

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K 0021 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Kitchen doors serving hazardous areas was held open only by a device arranged to automatically close the door or close the door upon activation of the fire alarm system. This deficient practice could affect staff and at least 12 residents in the main dining room which is open to the corridor.</p>	K 0021	<p>any trends found for non-compliance. ED will address audit results of the maintenance rounds 1 time monthly times 3 months with QAPI or until 3 months of audits maintain 100% compliance with regulation.</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p><b>K 021</b></p> <p><b>It is the practice of this facility to ensure that areas serving hazardous areas automatically close upon activation of the fire alarm system without obstruction in accordance with state and federal regulations.</b></p> <p><b><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></b></p>	04/01/2016

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	<p>Findings include:</p> <p>Based on observations with the Maintenance Director on 03/01/16 at 3:11 p.m., the kitchen rolling fire door was held open by a device attached to the wall. A lunch tray with dishes was directly underneath the rolling fire door. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<ul style="list-style-type: none"> <li>- Lunch tray was removed and area cleared from obstacles.</li> <li>- <b><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></b></li> </ul> <p>Facility walk through completed to ensure that fire doors/windows are free from obstacles to ensure that they are closed and secured in accordance with life safety regulations.</p> <p><b><u>Measures put in place to ensure alleged deficient practice does not recur:</u></b></p> <p>Staff in-service to review regulation guidelines. Signage in place next to the serving window to alert staff/visitors to not place items in serving window.</p> <ul style="list-style-type: none"> <li>- <b><u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></b></li> <li>- Maintenance Director will meet with ED 1 time a week to review audit records to identify and address any trends found for non-compliance. ED will address audit results of the maintenance rounds 1 time monthly times 3 months with QAPI or until 3 months of audits maintain 100% compliance with regulations.</li> <li>-</li> <li>-</li> </ul>		

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K 0025 SS=E Bldg. 01	<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 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>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 4 of 5 smoke barrier walls were 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 staff and up to 120 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Maintenance Technician #1 on 03/01/16 from 1:25 p.m. to 3:02 p.m., the following unsealed ceiling and corridor penetrations were discovered:</p> <p>a) two separate ceiling penetrations one eighth inch around cable in the Primrose Cable Room</p> <p>b) one of fifteen ceiling tiles were missing in the South West Main Entrance</p>	K 0025	<p><b>K 025</b></p> <p><b>It is the practice of the facility to ensure ceiling smoke barriers and smoke barrier walls were maintained to provide one half hour fire resistance rating in accordance with life safety code.</b></p> <p><b><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></b></p> <p>-</p> <p><b>A)</b> Primrose cable repaired.</p> <p><b>B)</b> Tile replaced in SW Main Entrance</p> <p><b>C)</b> Attic access panel replaced in the housekeeping storage room</p> <p><b>D)</b> Service corridor penetration corrected</p> <p><b>E)</b> Primrose Center Hall smoke barrier penetration corrected.</p> <p><b>F)</b> Primrose North Hall smoke barrier penetration corrected</p> <p><b>G)</b> South Entrance smoke barrier penetration corrected</p> <p><b>H)</b> East Entrance smoke barrier</p>	04/01/2016

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K 0038 SS=E Bldg. 01	<p>c) the attic access panel was removed from the Housekeeping Storage room</p> <p>d) a one and a half inch by two and a half inch corridor penetration in the service corridor</p> <p>Based on observations with the Maintenance Director and Maintenance Technician #1 on 03/02/16 from 10:58 a.m. to 11:42 a.m., the following unsealed smoke barrier penetrations above the drop ceiling were discovered:</p> <p>e) a two inch by two inch piece of drywall was cut out in the Primrose Center Hall smoke barrier</p> <p>f) a one inch by two inch piece of drywall was cut out in the Primrose North Hall smoke barrier</p> <p>g) a three feet by two feet of drywall was cut out in the South Entrance smoke barrier</p> <p>h) a three inch by five inch penetration in the East Entrance smoke barrier</p> <p>Based on interview at the time of each observation, the Maintenance Director acknowledged and provided the measurements for each unsealed penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are</p>		<p>penetrationcorrected.</p> <p>- <b><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></b></p> <p>- Maintenance Department completed 100% audit of remaining smoke barrierareas throughout building. No other identified areas at that time.</p> <p>- <b><u>Measures put intoplace to ensure alleged deficient practice does not recur:</u></b></p> <p>- Maintenance will complete once a quarter building audits and recordfindings as part of the preventative maintenance program to ensure that smokebarriers remain sealed according to life safety guidelines.</p> <p>- <b><u>How correctiveaction will be monitored to ensure alleged deficient practice does not recur:</u></b></p> <p>The maintenance director will turn in quarterly findings to the ED whowill review and discuss as part of the quarterly QAPI program. Findings will be part of the QAPI program for4 quarters and/or until result trends reach 100% with compliance in maintainingsmoke barriers within code regulations.</p> <p>-</p>				

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	<p>readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation, record review, and interview, the facility failed to ensure 1 of 1 Beauty Shop and 1 of 1 Ambulance Bay Door areas without a clinical diagnosis were allowed access to locked exit doors. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect up to 4 residents.</p> <p>Findings include: Based on observation with the Maintenance Director on 03/01/16 at 12:26 p.m. then again on 03/02/16 at 9:46 a.m., the following entrance/exit doors were held in the locked position with a magnetic hold down device. Furthermore, the following exit door was equipped with an electronic keypad entry system that allowed staff to open the locked exit doors with a combination. A code was not posted at the following</p>	K 0038	<p><b>K 038</b></p> <p><b>It is the practice of this facility to ensure that exits are readily accessible at all times in accordance with safety code regulations.</b></p> <p><b><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></b></p> <p>1) ExitCode was posted at the Beauty shop entrance and ambulance bay door. allowing staff and visitors easily exit access. 2) Exitcode was posted at the Primrose South Exit and South Tea room exit allowing staff and visitors easily exit access.</p> <p>-</p> <p>- <b><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></b></p> <p>- Maintenance completed facility rounds of all building exits to ensure that exit code was displayed allowing staff and visitors easily exit. No area areas were identified.</p> <p>- <b><u>Measures put into place to ensure alleged deficient practice does not recur:</u></b></p> <p>- Exit doors for building will be checked daily by the maintenance director/designee to ensure that the exit code remains</p>	04/01/2016

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	<p>entrance/exit doors:</p> <p>a) Beauty shop b) Ambulance Bay Door</p> <p>Based on an interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 Primrose South Wing exit and 1 of 1 South Tea Room exit was readily accessible at all times. This deficient practice could affect staff, visitors, and at least 22 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 03/01/16 between 1:50 p.m. and 3:39 p.m., the Primrose South Wing exit door, South Tea Room exit door, and Therapy exit door failed to release the magnetic lock when the code was entered. Based on an interview at the time of each observation, the Maintenance acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>				<p>posted at all times.</p> <p><b><u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></b></p> <p>- Maintenance Director will meet with ED 1 time a week to review audit records to identify and address any trends found for non-compliance. ED will address audit results of the maintenance rounds 1 time monthly times 3 months with QAPI or until 3 months of audits maintain 100% compliance with regulations</p>		

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K 0039 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 Based on observation, the facility failed to ensure 1 of 1 Service exit access corridors had a clear and unobstructed exit width of at least 4 feet (48 inches). This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 03/01/16 at 3:05 p.m., the Service access corridor had dishes outside the Kitchen on both sides of the corridor. The most restrictive area provided a clear width of thirty inches. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p>			K 0039	<p><b>K 039</b></p> <p><b>It is the practice of this facility to ensure corridors serving as exit access are in accordance with code regulations.</b></p> <p><b><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></b></p> <p>The service hall was cleared of items that were causing obstruction of the exit.</p> <p>- <b><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></b></p> <p>- The maintenance director completed facility rounds and observed all exit corridors to ensure they were clear of any obstruction. No additional areas were identified.</p> <p>- <b><u>Measures put in place to ensure alleged deficient practice does not recur:</u></b> Maintenance Director will complete morning and afternoon rounds throughout the building and will remove any items in corridors that are obstructing the exits. <b><u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></b></p>		04/01/2016

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K 0044 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self-closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect staff and at least 16 residents.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K 0044	<p>- Maintenance director will meet with the ED once a week for 4 weeks to review outcomes of his rounds. ED will review any issues or trends with the specific department for immediate correction. Round trends will be discussed during monthly QAPI for 3 months and until facility is maintaining 100% threshold compliance</p> <p><b>K 044</b></p> <p><b>It is the practice of this facility to ensure horizontal exits are in accordance with code regulations.</b></p> <p><b><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></b></p> <p>Rosewood dining room and Primrose fire doors were adjusted to latch when activation of fire alarm system.</p> <p>- <b><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></b></p> <p>- Fire drill was conducted and fire doors were checked to ensure closure when system activated. No other issues were noted.</p> <p>- <b><u>Measures put in place to ensure alleged deficient practice does not</u></b></p>	04/01/2016

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K 0046 SS=D Bldg. 01	<p>Maintenance Director on 03/01/16 at 12:15 p.m. then again at 12:41 p.m., the Rosewood Dining Room fire doors failed to latch when tested. Primrose fire doors failed to latch when tested. Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition and confirmed each set of doors were fire doors.</p> <p>3.1-19(b)</p> <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 1 of 1 Mechanical Equipment Room battery operated emergency lights in the facility was maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test.</p>	K 0046	<p><b><u>recur:</u></b></p> <ul style="list-style-type: none"> <li>- Maintenance Director/designee will check conduct fire door testing once aweek and will report findings to the ED.</li> <li>- <b><u>How correctiveaction will be monitored to ensure alleged deficient practice does not recur:</u></b></li> <li>- ED will review results oncea month during QAPI for 3 months, then 1 time a quarter for 4 months. Increased monitoring will be eliminated whenfacility reaches 100% compliance threshold</li> </ul> <p><b>K 046</b></p> <p><b>It is the practice ofthis facility to ensure Horizontal exits are in accordance with coderegulations.</b></p> <p><b><u>Corrective Actiontaken for residents found to be affected by alleged deficient practice:</u></b></p> <ul style="list-style-type: none"> <li>- Light was removed because it is no longer houses the facility generators.</li> </ul> <p><b><u>Identification ofother residents with potential to be affected by alleged deficient practice:</u></b></p> <ul style="list-style-type: none"> <li>- The emergency lighting at the current</li> </ul>	04/01/2016	

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K 0048 SS=E Bldg. 01	<p>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 staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 03/01/16 at 2:58 p.m., the battery operated emergency light in the Mechanical Equipment Room failed to illuminate when tested. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 1. Based on record review, observation, and interview, the facility failed to provide a written plan that addressed all components of the in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department</p>	K 0048	<p>generator was tested and working.</p> <p>- <b><u>Measures put in place to ensure alleged deficient practice does not recur:</u></b></p> <p>- Maintenance Director will complete morning rounds and will test the emergency generator light to make sure it is functioning properly.</p> <p><b><u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></b> Maintenance Director will meet with ED 1 time a week to review audit records to identify and address any trends found for non-compliance. ED will address audit results of the maintenance rounds 1 time monthly times 3 months with QAPI or until 3 months of audits maintain 100% compliance with regulation.</p> <p><b>It is the practice of this facility to have a written plan and to follow the plan for protection of all patients and their evacuation in the event of emergency.</b></p> <p><b><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></b> 1) The evacuation plan posted on the unit has been updated to show the correct evacuation door as to not go</p>	04/01/2016

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	<p>(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 This deficient practice could affect staff and 59 residents.</p> <p>Findings include:</p> <p>Based on a record review with the Maintenance Director on 03/02/16 at 11:14 a.m., the facility had a written fire policy that horizontal evacuation would be performed by crossing fire doors. Based on observation, there was a set of corridor doors near resident room 414. Based on interview, the Maintenance Director confirmed that set of doors were not part of a complete smoke barrier. The Maintenance Director acknowledged the fact the set of doors could be confused as a smoke barrier causing evacuation beyond the doors would still be in the same smoke compartment.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to provide a written plan that addressed all components of the in 1 of 1 written fire plans. LSC 19.7.2.2</p>		<p>through fire or smoke doors during evacuation process..</p> <p>2) C.N. Areceived education regarding proper evacuation routes for the halls in event of a hall fire.</p> <p>- <b><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></b></p> <p>- All residents have potential to be affected.</p> <p>- <b><u>Measures K 048 put into place to ensure alleged deficient practice does not recur:</u></b></p> <p>- Evacuation Routes will be reviewed as part of our monthly fire drill process and outcomes will be documented on the fire drill log.</p> <p>- <b><u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></b></p> <p>- The maintenance Director will turn in fire drill records to the ED who will review for any trends and educational needs. Any areas identified will be given to the specific department for individual training, etc. The ED will report to the QAPI team each month for 3 months on trends and recommendations for further action. Increased monitoring will be removed when facility reaches 3 months of achievement with 100% threshold compliance.</p>		

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	<p>requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice could affect staff and at least 26 residents.</p> <p>Findings include:</p> <p>Based on a record review on 03/01/16 between 9:37 a.m. and 11:22 a.m., the facility had a written fire policy that horizontal evacuation would be performed by crossing fire doors. Based on interview with a Certified Nursing Assistant at 3:25 a.m., was asked where she would evacuate residents in the event of a hallway fire. The Certified Nursing Assistant indicated she did not know where she would move the residents. Based on interview, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>						

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K 0050 SS=F Bldg. 01	<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>1. Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 1 of the last 4 calendar quarters. This deficient practice could affect all staff and residents.</p> <p>Findings include: Based on record review with the Maintenance Director on 03/01/16 at 10:46 a.m., the documentation for a first shift fire drill for the fourth quarter of 2015 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged the lack of documentation.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to conduct quarterly fire</p>	K 0050	<p><b>K 50</b> <b>It is the practice of this facility to ensure that fire drills are held in accordance with lifesafety code regulations.</b></p> <p><b><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></b></p> <p>1) The facility had discovered discrepancy prior to survey and had conducted the December fire drill in January.</p> <p>2) Maintenance Director received education on the requirements of fire drills and times according to code.</p> <p>- <b><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></b></p> <p>- All residents have potential to be affected.</p> <p>-</p>	04/01/2016

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K 0051 SS=F Bldg. 01	<p>drills at unexpected times for 3 of 4 quarters. This deficient practice affects all staff and residents.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 03/01/16 at 10:46 a.m., three sequential third shift fire drills took place between 4:51 a.m. and 5:10 a.m. for three of the last four quarters. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b) 3.1-51(c)</p> <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</p>		<p><b><u>Measures put intoplace to ensure alleged deficient practice does not recur:</u></b></p> <ul style="list-style-type: none"> <li>- A 2016 Fire Drill Calendar was developed and turned into the administratorfor review. ED reviewed to ensure that fire drill times have been establishedaccording to code expectations.</li> <li>- <b><u>How correctiveaction will be monitored to ensure alleged deficient practice does not recur:</u></b></li> <li>- Fire Drill records will be given to the ED for review each month, whowill compare to the 2016 fire drillcalendar for compliance. Results ofthose reviews will be discussed at Monthly QAPI for 6 months, then quarterlythereafter for 2 months. Increasedmonitoring can be reduced by QAPI team when facility complies with 100%compliance.</li> </ul>	

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	<p>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>1. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was provided in accordance with Section 9.6. Section 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, Section 7-4.3 states all apparatus requiring resetting to maintain normal operation shall be reset as promptly as possible after each test and alarms. This deficient practice could affect all clients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 03/01/16 between 11:22 a.m. and 3:45 p.m. and on 03/01/16 between 9:10 a.m. and 12:45 p.m., the following manual pull stations heights were discovered:</p> <p>a) 60 inches in Activities b) 60.5 inches in the Rosewood Dining Room c) 61 inches in the Primrose Entrance d) 60.5 inches in Therapy e) 60.75 inches in the Primrose Nurse's station</p>	K 0051	<p><b>K 51</b></p> <p><b>It is the practice of this facility to ensure that fire alarm systems are maintained in accordance with code regulations.</b></p> <p><b><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></b></p> <ul style="list-style-type: none"> <li>- Pull alarms cited in the survey are scheduled to be lowered by Viking Fire Protection on 4-4-16.</li> <li>- <b><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></b></li> <li>- All residents have potential to be affected.</li> <li>- <b><u>Measures put in place to ensure alleged deficient practice does not recur:</u></b></li> <li>- Any new construction that requires fire pull stations will be in compliance with code regulations.</li> </ul> <p><b><u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></b></p> <ul style="list-style-type: none"> <li>-</li> </ul>	04/01/2016

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	<p>f) 60.5 inches in the Primrose Center Hall g) 59 inches in the Primrose South Wing h) 60.5 inches in the South West Main Sitting Room i) 60.25 inches in the South West Center Hall j) 60.5 inches in the South West East Wing k) 60.5 inches near the Employee Smoking area exit door l) 59.75 inches in the Service Corridor m) 59.75 inches and 60.5 inches in the Kitchen n) 59.5 inches in Laundry o) 60 inches in the South Service Hall p) 61 inches near resident room 321 q) 60.5 inches by the Tea Room r) 61 inches near resident room 306 s) 61.5 inches in the South Boiler Room t) 61 inches near resident room 221 u) 60.5 near resident room 214 v) 54 inches resident room 206</p> <p>Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 smoke detector in Primrose Center Hall was not</p>		<p>Maintenance Director will inspect all new pull stations that are installed and will report to ED the results at the time work is completed. Issues identified will be addressed at the time and will be discussed at the next QAPI meeting for recommendations and further action plan needed.</p>	

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K 0056 SS=D Bldg. 01	<p>installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect staff at up to 12 residents.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Director on 02/01/16 at 1:19 p.m., the Primrose Center Hall had a smoke detectors located twenty six inches away from an HVAC vent. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p>			

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	<p>water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 sprinklers in the Primrose Pantry 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, Table 5-6.5.1.2 states that distance between a sprinkler head an obstruction less than 1 foot away cannot be lower than the sprinkler head deflector. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 03/01/16 at 1:35 p.m., the spray pattern for the sprinkler head in the Primrose Pantry was located next to a ceiling light. Measurements showed the light was three inches away from the sprinkler head. The ceiling lights were measured to be 0.5 inches lower than the sprinkler head deflector. Based on interview at the time</p>	K 0056	<p><b>K 56</b> <b>It is the practice of this facility to maintain sprinkler system with code regulations.</b></p> <p><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></p> <ul style="list-style-type: none"> <li>- The spray pattern for the sprinkler head in primrose pantry has been corrected in accordance with code regulations.</li> <li>- <u>Identification of other residents with potential to be affected by alleged deficient practice:</u></li> <li>- A one time facility audit was completed for lights next to sprinklerheads. No other areas were identified.</li> <li>- <u>Measures put into place to ensure alleged deficient practice does not recur:</u></li> <li>- A contractor checklist will be utilized for any electrical work/light installations and will be turned in to the maintenance director who will validate that work has been completed within code regulations.</li> <li>- <u>How corrective action will be monitored to ensure alleged</u></li> </ul>	04/01/2016

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K 0062 SS=D Bldg. 01	<p>of observation, the Maintenance Director acknowledged the abovementioned condition and provided the measurements.</p> <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>Based on observation and interview, the facility failed to replace painted or corroded sprinkler heads. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected 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 staff and at least 1 resident.</p>	K 0062	<p><b><u>deficient practice does not recur:</u></b></p> <p>- The maintenance director will meet with the ED prior to completion of the electrical work and will review outcome of the checklist. Trends or issues will be identified and taken to facility QAPI once a month for 3 months for recommendations. Reporting to QAPI will discontinue when facility has maintained 3 months of 100% threshold compliance.</p> <p>-</p> <p>-</p> <p><b>K 062</b></p> <p><b>It is the practice of this facility to ensure that automatic sprinkler systems are maintained in reliable operating condition in accordance with code regulations.</b></p> <p>- <b><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></b></p> <p>-</p> <p>a) Sprinklerhead changed in chapel.</p> <p>b) Sprinklerhead in 501 bathroom changed.</p> <p>c) Sprinklerhead in men's BR changed.</p>	04/01/2016
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K 0064 SS=E	<p>Findings include:</p> <p>Based on observation with the Maintenance Director on 03/01/16 between 12:26 p.m. and 3:14 p.m., the following sprinkler heads were discovered:</p> <p>a) 1 of 6 sprinkler heads were painted in the Chapel</p> <p>b) 1 of 1 sprinkler head was painted in resident room 501 bathroom</p> <p>c) 1 of 1 sprinkler head was painted in the Staff Men's Room</p> <p>d) 2 of 6 sprinkler heads were corroded and painted in the Prep Kitchen</p> <p>e) 4 of 4 sprinkler heads were corroded in the Dish room</p> <p>Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		<p>d) Sprinklerhead in prep kitchen changed.</p> <p>e) Sprinklerhead in dish room changed.</p> <p>- <b><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></b></p> <p>- Maintenance Director conducted a audit of the building sprinkler heads.</p> <p>- <b><u>Measures put in place to ensure alleged deficient practice does not recur:</u></b></p> <p>- Maintenance Director/designee will complete audits of each unit once a week, and in addition any paint projects that have been completed for the week. Maintenance Director will address any areas identified and will in service painting staff on the maintenance of sprinkler heads.</p> <p>- <b><u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></b></p> <p>- Maintenance Director will meet with ED 1 time a week to review audit records to identify and address any trends found for non-compliance. ED will address audit results of the maintenance rounds 1 time monthly times 3 months with QAPI or until 3 months of audits maintain 100% compliance with regulation</p>				

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Bldg. 01	<p>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>1. Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers at the Primrose Entrance, South West Main Sitting Room, South West Center Hall, and Kitchen was installed correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect staff and 22 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on /16 between 12:36 p.m. and 3:12 p.m., the following fire extinguisher heights were discovered:</p> <p>a) 62 inches at the Primrose Entrance b) 66.5 inches in the South West Main Sitting Room c) 62 inches in the South West Center Hall d) 63 inches in the Kitchen</p> <p>Based on interview at the time of observation, the Maintenance Director</p>	K 0064	<p><b>K 064</b></p> <p><b>It is the practice of this facility to provide fire extinguishers in accordance with code regulations.</b></p> <p><b><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></b></p> <ul style="list-style-type: none"> <li>- 1) Fire extinguishers on Primrose, SW sitting room, SW Center Hall and Kitchen have been corrected to code standard.</li> <li>- 2) Fire extinguisher near room 221 has been replaced.</li> </ul> <p><b><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></b></p> <ul style="list-style-type: none"> <li>- Maintenance Director has completed a facility audit of remaining fire extinguishers. Facility did not identify any new extinguishers that needed replaced or relocated to be in compliance with code regulations.</li> </ul> <p><b><u>Measures put in place to ensure alleged deficient practice does not recur:</u></b></p> <ul style="list-style-type: none"> <li>- Maintenance Director will keep a extinguisher log that will identify each extinguisher's expiration date to ensure that extinguishers will receive appropriate maintenance as needed in accordance with the code regulations.</li> </ul>	04/01/2016

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K 0066 SS=D Bldg. 01	<p>acknowledged the aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguishers by resident room 221 requiring a 12-year hydrostatic test was emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect staff and up to 15 residents.</p> <p>Findings include:</p> <p>Based on observation and interview with the Maintenance Director on 03/02/16 at 10:00 a.m., the fire extinguisher near resident room 221 maintenance tag indicated the last six year test was completed 01/10. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</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>- <b><u>How correctiveaction will be monitored to ensure alleged deficient practice does not recur:</u></b></p> <p>- Maintenance Director will meet with ED 1 time a week to reviewaudit records to identify and address any trends found for non-compliance. EDwill address audit results of the maintenance rounds 1 time monthly times 3months with QAPI or until 3 months of audits maintain 100% compliance with</p>		

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	<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 3 of 4 area 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 staff only.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 03/01/16 between 1:06 p.m. and 2:35 p.m., the following was discovered:</p> <p>a) Primrose smoking area contained at least 50 cigarette butts on the ground</p> <p>b) South West Main Entrance smoking</p>	K 0066	<p><b>K 066</b></p> <p><b>It is the practice of this facility to maintain a smoking policy in accordance with code regulations.</b></p> <p>- <b><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></b></p> <p>- a) Primrose Entrance was cleaned. This is not a designated smoking area.</p> <p>b) South West Entrance was cleared of cigarette butts.</p> <p>c) South East is a designated smoking area and was cleared of cigarette butts. The metal container was replaced with appropriate enclosure containers that are in accordance with code regulations.</p> <p>- <b><u>Identification of other residents</u></b></p>	04/01/2016

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	<p>area contained at least 30 cigarette butts on the ground</p> <p>c) South East Wing smoking area contained at least 20 cigarette butts on the ground and a tin can without a lid with cigarette butts with one cigarette still producing smoke.</p> <p>Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p><b><u>with potential to be affected by alleged deficient practice:</u></b></p> <ul style="list-style-type: none"> <li>- Maintenance completed exterior clean-up around facility grounds.</li> <li>- <b><u>Measures put intoplace to ensure alleged deficient practice does not recur:</u></b></li> <li>- Maintenance Director/designee will complete daily rounds at all entranceways and will clean areas as needed. Acceptable containers have been placed in designated smoking areas, withsignage posted in other areas that are not designated for smoking. Maintenance Director/designee will meet with residents and staff toreview the current smoking policy.</li> <li>- <b><u>How correctiveaction will be monitored to ensure alleged deficient practice does not recur:</u></b></li> <li>- Maintenance Director will provide results of daily rounds to the ED for review. ED will make exterior rounds once a week andwill address any areas identified with appropriate departments. Rounds results will be reviewed during QAPonce a month for 3 months or until 100% compliance is achieved.</li> <li>-</li> <li>-</li> <li>-</li> <li>-</li> <li>-</li> <li>-</li> </ul>	

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K 0067 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Service hall egress corridors was not being used as a portion of the supply air plenum for heating, ventilating and air conditioning ductwork (HVAC) serving adjoining areas. NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice was not in a resident care area but could affect facility staff in the service hall.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 03/01/16 between 11:22 a.m. and 3:45 p.m., the service hall was provided with only supply vents. Based on an interview at the time of observation, the Maintenance Director confirmed the returns vents for the service corridor ventilation system were located in the housekeeping office, break room and the central supply rooms.</p>	K 0067	The facility is submitting a life safety code wavier request for this tag	04/01/2016			

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K 0069 SS=E Bldg. 01	<p>3.1-19(b)</p> <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 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 Activities kitchens. NFPA 96, 7-1.2 requires cooking equipment that 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.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 12:06 p.m., an oven/stovetop without an extinguishing system was discovered in the Activities room. Based on interview at the observation, when asked, the Activities Director confirmed that bacon and sausage was cooked on the</p>	K 0069	<p><b>K 069 It is the practice of this facility to provide cooking facilities in accordance with coderegulations. <u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u> _ The facility has installed a disconnect for the range, which will be kept locked at all times and will have limited access to activity staff and supervision. <u>Identification of other residents with potential to be affected by alleged deficient practice:</u> _ All residents participating in activities have potential to be affected. _ <u>Measures put into place to ensure alleged deficient practice does not recur:</u> _ A sign will be posted on the top of the stove that will prohibit cooking any greasy food items and will identify the oven as the only thing available for resident cooking activity. Activity Staff will receive in service training on the new changes. _ <u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u> _ Maintenance Director will check Activity area during daily morning rounds to make sure that</b></p>	04/01/2016

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K 0075 SS=E Bldg. 01	<p>oven/stovetop. The Maintenance Director acknowledged the aforementioned condition.</p> <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 1 East Lounge. This deficient practice could affect staff and 44 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 03/02/16 at 10:16 a.m., the East Lounge which is open to the corridor contained two</p>	K 0075	<p>the signage is still in tact and the disconnect cabinet is locked when not in use. Maintenance Director will review weekly with ED the results of his rounds and will report the results to QAPI team once a month for 3 months or until 100% compliance threshold is met. _</p> <p><b>K 075</b> <b>It is the practice of this facility to ensure that facility soiled linen/trash containers are in accordance with code regulations.</b></p> <p><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></p> <ul style="list-style-type: none"> <li>- The gallon containers were removed from East Unit.</li> <li>- <u>Identification of other residents with potential to be affected by alleged deficient practice:</u></li> <li>- Hall audits were conducted and</li> </ul>	04/01/2016	

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K 0130 SS=E Bldg. 01	<p>separate 32 gallon containers used for soiled linen. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review and interview, the facility failed to ensure a battery replacement program was provided to ensure 110 of 110 single station smoke</p>	K 0130	<p>containers that were identified wereremoved from the unit.</p> <ul style="list-style-type: none"> <li>- <b><u>Measures put intoplace to ensure alleged deficient practice does not recur:</u></b></li> <li>- Current linen/trash containers replaced with new containers that do notexceed 32 gallons.</li> </ul> <p><b><u>How correctiveaction will be monitored to ensure alleged deficient practice does not recur:</u></b></p> <ul style="list-style-type: none"> <li>- Maintenance Director/designee will monitor the hallways during daily rounds to make sure that there are no 32gallon containers in use. Any found willbe immediately be taken off the floor and replaced with appropriate containerswithin code. Maintenance Director willreport to the ED once a week his findings and ED will address identifiednon-compliance with the appropriate department. ED will report progress to the QAPI team once a month for 3 months or until 100% threshold compliance is reached</li> </ul> <p><b>K 130</b> <b>It is the practice ofthis facility to ensure a battery replacement program is in place in accordancewith code regulations.</b></p>	04/01/2016

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	<p>detectors would operate. This deficient practice affects staff and at least 152 residents.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 03/01/16 at 10:29 a.m., the "Battery-operated smoke detector maintenance log for 2016" did not have documentation indicating a battery replacement program for the 400 Hall and 500 Hall station smoke detectors. Based on an interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 110 of 110 single station smoke detectors were tested monthly. This deficient practice affects 152 residents.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 03/01/16 at 10:29 a.m., the "Battery-operated smoke detector maintenance log for 2016" did not have documentation indicating testing for January of 2016. Based on interview</p>		<p><b><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></b></p> <ul style="list-style-type: none"> <li>- 1) Documentation found for 400 and 500 hall to show they had been checked and functioning properly.</li> <li>2) Maintenance Director was in-serviced regarding maintaining a log for monthly testing. January log was found.</li> <li>3) Activity Office fire barrier repaired. Primrose fire barrier repaired</li> </ul> <p>- <b><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></b></p> <ul style="list-style-type: none"> <li>- Maintenance director checked all fire barriers, battery operated smoke detectors. No issues found with fire barriers. Batteries were replaced.</li> </ul> <p>- <b><u>Measures put in place to ensure alleged deficient practice does not recur:</u></b></p> <ul style="list-style-type: none"> <li>- A maintenance binder will be kept with all records involving the battery operated smoke detectors.</li> </ul> <p><b><u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></b></p> <ul style="list-style-type: none"> <li>- The Maintenance Director and ED will review the binder during weekly department meeting to discuss outcomes and to identify</li> </ul>				

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	<p>at the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure the penetration in 2 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:</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</p>		<p>trends. Any issues will be addressed through the facility QAPI team. Monitoring will be discussed once a month for 3 months, or until facility has reached and maintained 3 months of 100% compliance</p>				

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K 0143 SS=E Bldg. 01	<p>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 staff and up to 12 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 03/02/16 at 10:44 a.m. then again at 10:46 a.m., two separate one inch penetrations in the Activities office fire barrier. Then again three penetrations were sealed with an expandable foam product in the Primrose fire barrier. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition and provided the measurements. No documentation was available for review for the expandable foam product.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p>				

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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELY AVE ELKHART, IN 46517
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	<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>1. Based on observation and interview, the facility failed to ensure 1 of 4 areas used for transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire-resistive construction. This deficient practice could affect staff and 48 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 03/02/16 at 1:59 p.m., a Certified Nurse's Assistant was transfilling oxygen with the South West oxygen room corridor door open. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p>	K 0143	<p><b>K 143</b> <b>It is the practice of the facility to transport Oxygen in accordance with code regulations.</b></p> <p><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></p> <ul style="list-style-type: none"> <li>- 1) C.N. Awas in-serviced on the facility policy regarding transferring the Oxygen</li> <li>2) GAP was resealed fire retardant caulk.</li> <li>3) The exhaust fans in Primrose, East and Southwest were replaced and are working.</li> </ul> <p><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></p> <ul style="list-style-type: none"> <li>- The south unit was checked and was working. No other areas in building.</li> </ul> <p><u>Measures put in place to ensure</u></p>	04/01/2016

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 4 areas used for transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire-resistive construction. This deficient practice could affect staff and up to 44 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 03/03/16 at 10:22 a.m., an eighty inch gap from the floor to the top of the door frame was a gap in the wall through to the oxygen storage room. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 3 of 4 liquid oxygen storage areas where oxygen transferring takes place, was provided with continuous mechanical ventilation. This deficient practice could affect staff only.</p>		<p><b><u>alleged deficient practice does not recur:</u></b></p> <p>- The maintenance Director has developed and will keep a monthly log that the complete preventative maintenance on the exhaust fans throughout the building. All staff will complete work orders immediately when equipment found to be not functioning properly.</p> <p>- <b><u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></b></p> <p>- Maintenance Director will meet with ED 1 time a week to review audit records to identify and address any trends found for non-compliance. ED will address audit results of the maintenance rounds 1 time monthly times 3 months with QAPI or until 3 months of audits maintain 100% compliance with regulation</p>		

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K 0147 SS=D Bldg. 01	<p>Findings include:</p> <p>Based on observation with the Maintenance Director, the following oxygen transfill room's fans were not working:</p> <p>a) Primrose at 1:10 p.m. on 03/01/16 b) South West Center Hall at 2:16 p.m. on 03/01/16 c) East Wing at 10:22 a.m. on 03/02/16</p> <p>Each fan was checked with a piece of paper. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition.</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 2 of 2 multiplugs and 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 cables shall not be used as a substitute for fixed wiring of a structure. This deficient</p>	K 0147	<p><b>K 147</b></p> <p><b>It is the practice of this facility to maintain electrical wiring and equipment in accordance with code requirements..</b></p> <p><b><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></b></p> <p>a) Surgeprotector and plug removed from room. Refrigerator also was removed by the family.</p>	04/01/2016

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	<p>practice affects staff and up to 2 residents.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Director on 03/01/16 between 2:04 p.m. to 3:06 p.m. the following was discovered:</p> <p>a) a surge protector was powering an air conditioner and a refrigerator in resident room 420. Also, a bed was plugged into a multiplug adapter.</p> <p>b) an extension cord powering a fan and a radio in the kitchen</p> <p>Based on observation with Maintenance Director on 03/02/16 between 9:28 a.m. to 9:38 a.m. the following was discovered:</p> <p>c) a multiplug was powering phone equipment in the South Boiler Room</p> <p>d) a surge protector was powering a coffee pot in the Director of Nursing office</p> <p>Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p>b) Extensioncord in kitchen was removed.</p> <p>c) Multiplugin south boiler was removed</p> <p>d) Coffeepot was removed from the DON office</p> <p><b><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></b></p> <p>1 time facility rounds made throughout building, no other extension cords or equipment were found to be affected.</p> <p>-</p> <p>-</p> <p><b><u>Measures put in place to ensure alleged deficient practice does not recur:</u></b></p> <p>-</p> <p>Guardian Rounds program was implemented which as part of that program, each department head is assigned a group of rooms/residents they are responsible to check in with on a daily basis and also require that they check the rooms for extension cords and other equipment not in compliance with code regulation.</p> <p>-</p> <p>-</p> <p><b><u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></b></p> <p>Guardian rounds sheets are turned into the ED daily who in turn creates a list for Maintenance Director to address. We also use work orders as a way for communication to the</p>	

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			maintenancedepartment. ED/Maintenance Director willdiscuss rounds results during weekly department meeting to identify trends anddevelop action plan. Progress will bereviewed with QAPI team once a month for 60 days or until 100% compliancethreshold is achieved.		