

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155287	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2011
NAME OF PROVIDER OR SUPPLIER RENSELAER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSELAER, IN47978		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/22/11</p> <p>Facility Number: 000185 Provider Number: 155287 AIM Number: 100290840</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Rensselaer Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility and it's additions were built prior to March 1, 2003, therefore they were surveyed in</p>	K0000	<p>9.9.11 This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied</p>		

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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K0018 SS=E	<p>accordance with LSC Chapter 19. The facility was determined to be Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 157 and had a census of 101 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/31/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p> <p>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.</p>				

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	<p>1. Based on observation and interview, the facility failed to ensure there were no impediments to closing doors protecting corridor openings in 3 of 7 smoke compartments. This deficient practice affects staff, visitors and 77 residents in the west core, east core and special care units.</p> <p>Findings include:</p> <p>Based on observations with the maintenance director on 08/22/11 between 11:00 a.m. and 2:45 p.m., the corridor doors to rooms 202 and 212 were held open with kick down door stops. A thick rubber floor mat prevented the door to resident room 411 from closing and privacy curtains were hung in the path of the doors to resident rooms 304 and 411 which prevented them from closing. The maintenance director said at the times of observation, he did not know the impediments were there.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to</p>	K0018	<p>K0181. Corrective action accomplished for Residents affected by the alleged deficient practice. Rooms 202 and 212 had kick down doorstops immediately removed. Rooms 411 had floor mat immediately removed and privacy curtain was re-hung so to not be in the path of doors 304 and 411. Rooms 201 and 012 had doors that were immediately adjusted to latch properly. The double door set at the core dining room was adjusted to latch properly. 2. How Facility reviewed all residents who could be affected by the same alleged deficient practice. Maintenance Supervisor conducted a facility wide audit in regards to all fire doors on August 22nd, 2011. What systemic changes the facility has made to ensure the alleged deficient practice does not occur. All Fire Doors shall be inspected to ensure functioning and code compliance 1X per week for 4 weeks and then monthly thereafter for 3 months. If 95% compliance is achieved auditing will be discontinued after review in PI meeting. 4. How corrective actions will be monitored to ensure that alleged deficient practice will not reoccur. Preventative Maintenance logs will be reviewed in the safety committee meeting quarterly to ensure continued compliance for one year following the noted issue. 5. Date of systemic</p>	09/21/2011	

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	<p>ensure doors protecting corridor openings in 3 of 7 smoke compartments would latch. This deficient practice affects staff, visitors and 30 or more residents in the special care unit and core dining room.</p> <p>Findings include:</p> <p>Based on observations with the maintenance director on 08/22/11 between 11:30 a.m. and 2:45 p.m., the doors to rooms 201, 12 and one door in the double door set to the core dining room failed to latch after being tested twice. The maintenance director said at the time of observation, the latches would need adjustment.</p> <p>3.1-19(b)</p>		changes9.21.11		

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K0021 SS=B	<p>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 6 of 9 doors to hazardous areas on the northeast wing such as storage rooms larger than 50 square feet in size would self close. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects 4 occupants observed in the northeast wing.</p> <p>Findings include:</p>	K0021	<p>K021 Corrective action accomplished for Resident affected by the alleged deficient practice: Resident rooms 8,10,14,15 were equipped with self-closing devices, completed on 9.12.11. Resident rooms 17 and 21 were emptied out on 9.8.11. 2. How Facility reviewed all residents who could be affected by the same alleged deficient practice. Whole house audit of empty resident rooms was conducted on 9.9.11 to ensure that they were not being used for storage. 3. A systemic change the facility has made to ensure the alleged deficient practice does not occur. A facility in service will be conducted on 9.15.11 regarding proper room storage. Conducted by Maintenance supervisor.</p>	09/21/2011	

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K0027 SS=E	<p>Based on observations with the maintenance director on 08/22/11 between 11:15 a.m. and 2:45 p.m., resident rooms 8, 10, 14, 15, 17, and 21 were used for storing miscellaneous cardboard cartons, linen and other combustibles. The former resident rooms were each larger than 50 square feet and were not equipped with self closing devices. The maintenance director said at the time of observation, he was unaware these rooms, used temporarily for storage needed the self closers.</p> <p>3.1-19(b)</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>1. Based on observation and</p>	K0027	<p>4. How corrective actions will be monitored to ensure that alleged deficient practice will not reoccur. Empty room audit will be conducted 1 X per week for 4 weeks then monthly X 3 months. If 95% compliance is achieved the PI committee will determine if further auditing is necessary.</p> <p>5. By what date the systemic changes will be completed. 9.21.11</p> <p>K 027 1. Corrective action</p>	09/21/2011	

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	<p>interview, the facility failed to provide 6 of 6 first floor smoke barrier door sets with the appropriate hardware to allow the door which must close first, to always close first to ensure both doors always close completely. CMS requires smoke barrier doors equipped with an astragal have a coordinator to ensure the door that must close first always closes first. This deficient practice could visitors, staff and 101 residents on the east, west and south and center core wings.</p> <p>Findings include:</p> <p>Based on observation the maintenance director on 08/22/11 between 11:30 a.m. and 2:45 p.m., doors in double door smoke barrier door sets protecting the east, west and south core units each had an astragal on one of the two doors and closed in the same direction. The door sets were not equipped coordinators to assure the doors would close in the proper sequence each time. The maintenance director said at the time of observations, he had timed the doors to close in the proper</p>		<p>accomplished for Resident affected by the alleged deficient practice: All doors were inspected to ensure that closing occurs to regulation.</p> <p>2. How Facility reviewed all residents who could be affected by the same alleged deficient practice. All doors were reviewed to ensure that timing was such that the proper sequence of door closing occurred</p> <p>3. A systemic change the facility has made to ensure the alleged deficient practice does not occur. Order completed on 9.15.11 in regards to Double door astragal/coordinator to ensure that one door closes prior to the other.</p> <p>4. How corrective actions will be monitored to ensure that alleged deficient practice will not reoccur. All doors in the facility will be inspected and reviewed monthly during the routine preventative maintenance safety checks. Results of audit will be brought to safety committee meeting for review.</p> <p>5. By what date the systemic changes will be completed. 9.21.11</p>		

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	<p>sequence.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 6 smoke barrier door sets in the core smoke compartments would self close to restrict the passage of smoke. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect staff, visitors and 24 or more residents in the east core unit and center core lounge.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/22/11 between 11:30 a.m. and 2:45 p.m., one door in the smoke barrier door set between the center core lounge and core east wing was held wide open by a straight back chair. The maintenance supervisor agreed at the time of observation, the door should not be prevented from closing.</p>				

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K0029 SS=E	<p>3.1-19(b)</p> <p>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 provide automatic closer devices on hazardous room doors in 2 of 8 smoke compartments. This deficient practice affects visitors, staff and 24 residents on the 100 core unit.</p> <p>Findings include:</p> <p>Based on observation on 08/22/11 at 2:00 p.m. with the maintenance director, resident room 100 had a two bin receptacle for the collection of soiled linens</p>	K0029	<p>K 029</p> <p>1. Corrective action accomplished for Resident affected by the alleged deficient practice: Room had the 2 bin receptacle removed on 8/23/11.</p> <p>2. How Facility reviewed all residents who could be affected by the same alleged deficient practice. Facility audit was conducted for hazardous conditions on 9.8.11 with out findings.</p> <p>3. A systemic change the facility has made to ensure the alleged deficient practice does not occur. Inservice conducted on 9.15.11 to review hazardous conditions in</p>	09/21/2011	

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K0038 SS=D	<p>and trash which was half full. The corridor access door was not equipped with a self closing device and stood wide open. The maintenance director said at the time of observation, each receptacle had the capacity for 32 gallons and he was not aware the door required a self closing device.</p> <p>3.1-19(b)</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure an exit access door in 1 of 5 smoke compartments was provided with a means to open under all lighting conditions. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one which is familiar to</p>	K0038	<p>resident rooms and what to do when you encounter such condition.</p> <p>4. How corrective actions will be monitored to ensure that alleged deficient practice will not reoccur. Audit will be conducted monthly during routine preventative maintenance checks and result will be reviewed in safety committee meeting.</p> <p>5. By what date the systemic changes will be completed. 9.21.11</p> <p>K 038</p> <p>1. Corrective action accomplished for Resident affected by the alleged deficient practice: South kitchen door had the dead bolt removed on 9.8.11</p> <p>2. How Facility reviewed all residents who could be affected by the same alleged deficient practice. Exit doors were reviewed on 9.7.11 and were found to be in compliance.</p> <p>3. A systemic change the facility has made to ensure the</p>	09/21/2011	

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K0046 SS=E	<p>the average person. For example, a two step release, such as a knob and independent dead bolt, is not acceptable. In most occupancies, it is important that a single action unlatch the door. This deficient practice could affect 4 kitchen staff.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/22/11 at 2:20 p.m. the south kitchen door had deadbolt and panic hardware latches which required opening to exit. The maintenance director agreed at the time of observation, the arrangement would require two actions to open the door when the deadbolt was engaged.</p> <p>3.1-19(b)</p> <p>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 16 battery powered emergency lighting fixtures would</p>	K0046	<p>alleged deficient practice does not occur.</p> <p>Dead bolt no longer utilized for South kitchen door.</p> <p>4. How corrective actions will be monitored to ensure that alleged deficient practice will not reoccur.</p> <p>Audit will be conducted weekly for 4 weeks to ensure that all exit doors are in standard compliance. If after 4 weeks of 100% compliance the Safety committee will determine if further auditing is necessary.</p> <p>5. By what date the systemic changes will be completed.</p> <p>9.21.11</p> <p>K046</p> <p>1. Corrective action accomplished for Resident affected by the alleged deficient practice:</p>	09/21/2011	

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K0048 SS=C	<p>operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors, staff and 22 residents on the special care unit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/22/11 between 1:00 p.m. and 3:00 p.m., the battery powered emergency discharge lighting from the east and west special care unit exits failed to illuminate when tested twice. The maintenance director said at the times of observation, he did not know the lights were not working.</p> <p>3.1-19 (b)</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the evacuation of the smoke compartment in the written fire plan for the protection of 101</p>	K0048	<p>East and West halls in special care had the light bulbs immediately repaired.</p> <p>2.How Facility reviewed all residents who could be affected by the same alleged deficient practice. Facility audit was conducted for all emergency lighting conditions on 9.1.11 with out findings.</p> <p>3. A systemic change the facility has made to ensure the alleged deficient practice does not occur. In service conducted on 9.15.11 to review hazardous conditions with in facility grounds and what to do when you encounter such condition.</p> <p>4. How corrective actions will be monitored to ensure that alleged deficient practice will not reoccur. Audit will be conducted monthly during routine preventative maintenance checks and result will be reviewed in safety committee meeting.</p> <p>5. By what date the systemic changes will be completed. 9.21.11</p> <p>K048 1. Corrective action accomplished for Resident affected by the alleged deficient practice: Policy and Procedure was</p>	09/21/2011			

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	<p>of 101 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Fire Policy and Procedure with the maintenance director and administrator on 08/22/11 at 12:00 p.m., the plan did not address the use of and types of fire extinguishers for extinguishment of fire. The maintenance director said, and the administrator confirmed at the time of record review, use of fire extinguishers was covered in an</p>		<p>revised to include types of fire extinguishers and use of fire extinguishers.</p> <p>2.How Facility reviewed all residents who could be affected by the same alleged deficient practice. Facility audit on fire extinguishers were conducted on 9.1.11 with out findings.</p> <p>3. A systemic change the facility has made to ensure the alleged deficient practice does not occur. Inservice conducted on 9.15.11 to review extinguisher policy and procedure.</p> <p>4. How corrective actions will be monitored to ensure that alleged deficient practice will not reoccur. Audit will be conducted monthly during routine preventative maintenance checks and result will be reviewed in safety committee meeting.</p> <p>5. By what date the systemic changes will be completed. 9.21.11</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K0061 SS=F	<p>annual inservice but it was not included in the written fire safety policy.</p> <p>3.1-19(b)</p> <p>Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler system post indicator valves was supervised. NFPA 101, 9.7.2.1 requires supervisory attachments shall be installed and monitored for integrity and a distinctive supervisory signal shall be provided to indicate a condition which would impair the satisfactory operation of the sprinkler system. Monitoring shall include control valves such as the post indicator valve. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation on 08/22/11 at 11:00 a.m., the post</p>	K0061	<p>K061</p> <p>1. Corrective action accomplished for Resident affected by the alleged deficient practice: Safe care was called to set up a date to have PIV placed on electric monitoring. Safe Care reviewed on 9.8.11</p> <p>2. How Facility reviewed all residents who could be affected by the same alleged deficient practice. All PIV valves were inspected to ensure electric monitoring exist.</p> <p>3. A systemic change the facility has made to ensure the alleged deficient practice does not occur. Maintenance director and assistant reviewed regulation on 9.8.11 and have become educated on standard.</p> <p>4. How corrective actions will be monitored to ensure that alleged deficient practice will not reoccur. The tamper switch will be</p>	09/21/2011	

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K0062 SS=E	<p>indicator valve (PIV), a control valve for the automatic sprinkler system was located in the front of the facility. The PIV was chained but there was no evidence of any electronic supervision. On 08/22/11 at 11:30 a.m., the maintenance director said he thought the valve was supervised but could provide no evidence. He called the sprinkler system contractor immediately and reported the valve was secured with a chain as required by NFPA 25, but no supervisory attachment was in place.</p> <p>3.1-(19)b</p> <p>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 ensure sprinkler heads in 2 of 5 smoke compartments were free of foreign materials, such as paint. NFPA 25, 2-2.1.1 requires sprinklers to be free of paint. This deficient practice could affect staff, visitors and 54 residents in the core south and core east units.</p>	K0062	<p>maintained through quarterly inspections from Service Company. Results of inspections will be reviewed in the safety committee meeting.</p> <p>5. By what date the systemic changes will be completed. 9.21.11</p> <p>K062</p> <p>1. Corrective action accomplished for Resident affected by the alleged deficient practice: On 8.22.11 a 100% audit was conducted to review all sprinkler heads that needed to be replace. Audit was conducted by Maintenance supervisor.</p>	09/21/2011	

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K0068 SS=F	<p>Findings include:</p> <p>Based on observations with the maintenance director on 08/22/11 between 11:30 p.m. and 2:50 p.m., sprinkler heads in the activities office, social services office, rooms and/or restrooms in 104, 106, 108, 109, 110 and 111 each had paint on them. The maintenance director agreed at the times of observation, the sprinkler heads should be clean to ensure they operated correctly.</p> <p>3.1-19(b)</p> <p>Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 water heater rooms were provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice</p>	K0068	<p>2. How Facility reviewed all residents who could be affected by the same alleged deficient practice. 100% Facility audit of sprinkler system was conducted 9.8.11 by Safe Care. All sprinkler heads were ordered for replacement that placed facility out of compliance.</p> <p>3. A systemic change the facility has made to ensure the alleged deficient practice does not occur. In service conducted on 9.15.11 to review standard for sprinkler head.</p> <p>4. How corrective actions will be monitored to ensure that alleged deficient practice will not reoccur. Audit will be conducted monthly during routine preventative maintenance checks and result will be reviewed in safety committee meeting.</p> <p>5. By what date the systemic changes will be completed. 9.21.11</p> <p>K068 1. Corrective action accomplished for Resident affected by the alleged deficient practice: All boiler rooms were inspected and reviewed for combustible air supply on 8.22.11</p>	09/21/2011	

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	<p>could create an atmosphere rich with carbon monoxide which could cause physical problems for 2 residents observed in the Lobby as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/22/11 between 11:00 a.m. and 3:15 p.m., rooms for the gas fuel fired water heaters on core units south, east and west had no fresh air intake. The maintenance director acknowledged at the times of observation, the rooms with fuel fired water heaters did not have a fresh air intake.</p> <p>3.1-19(b)</p>		<p>2. How Facility reviewed all residents who could be affected by the same alleged deficient practice. Boiler rooms on East hall, South hall and West hall were installed with intake combustion air vents from the outside on 9.7.11</p> <p>3. A systemic change the facility has made to ensure the alleged deficient practice does not occur. Maintenance supervisor and assistant reviewed regulation on 9.8.11 to understand compliance issue.</p> <p>4. How corrective actions will be monitored to ensure that alleged deficient practice will not reoccur. Audit will be conducted monthly during routine preventative maintenance checks to ensure vents are working properly and result will be reviewed in safety committee meeting.</p> <p>5. By what date the systemic changes will be completed. 9.21.11</p>		