

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/15/2015
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NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
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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 Date: 12/15/15</p> <p>Facility Number: 000022 Provider Number: 155061 AIM Number: 100274510</p> <p>At this Life Safety Code Survey, Woodland Hills 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 three story facility with a basement was determined to be of Type II (222) construction and fully sprinkled except the two front porch overhangs. The facility has a fire alarm system with smoke detection on all levels including the basement, the corridors, spaces open to the corridors and hard wired smoke detectors in all resident sleeping rooms.</p>	K 0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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K 0018 SS=C Bldg. 01	<p>The facility has a capacity of 100 and had a census of 38 at the time of this survey.</p> <p>All areas providing facility services were sprinkled and all areas where residents have customary access were sprinkled. Quality Review completed 12/22/15 - 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 the 3 of 111 corridor room doors were capable of resisting the passage of smoke or provided with a suitable means for keeping the doors closed. This deficient practice affects staff only who work in the basement.</p> <p>Findings include:</p>	K 0018	<p>It is the intent of this facility to maintain physical plant to meet State and Federal guide lines The 3 doors in question have been replaced or repaired All residents have the potential to be affected, no resident have been found to be affected by this sighting</p> <p>It is anticipated that maintenance personnel will observe the hallways and common areas of the facility throughout the normal</p>	01/14/2016

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K 0029 SS=E Bldg. 01	<p>Based on observations with the maintenance supervisor on 12/15/15 during a tour of the basement from 9:55 a.m. to 10:45 a.m., the minimum data set coordinator office room door had a one inch gap along the latching side of the door in the closed position. Furthermore, the basement clean utility room door lacked latching hardware and the basement beauty shop frame was rusted through on both sides of the door, which left the corridor door opening incapable of resisting the passage of smoke. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 12/15/15 at 2:50 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are</p>		<p>course of each scheduled work day When a full observation or a work order is completed the status of the repair will be noted on interior observation log. Preventive Maintenance Logs have been established to monitor the conditions of facility doors and other maintenance programs The Maintenance Man will check 10 doors weekly for 4 weeks then check 10 doors monthly on going to verify or identify any doors needing adjusting or repaired PM Logs will be reviewed at monthly QA meeting</p>	

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	<p>permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 5 of 13 hazardous areas, such as storage rooms over 100 square feet, fuel fire equipment rooms, and a laundry room over 100 square feet, were provided with smoke resistant doors. This deficient practice could affect 10 residents who reside on the second floor and staff who work in the basement.</p> <p>Findings include:</p> <p>Based on observations on 12/15/15 during a tour of the facility with the maintenance supervisor from 9:55 a.m. to 2:45 p.m., the basement nursing storage room, the basement kitchen storage room and the second floor soiled linen room corridor doors each had a one inch to three inch gap along the latching sides of the doors in the closed position and the basement gas furnace room door had a one half inch diameter circular hole in the door next to the door knob. Furthermore, the basement kitchen metal door and the basement laundry room metal door were separating in the center of each door and failed to resist the passage of smoke. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 12/15/15 at 2:50 p.m.</p>	K 0029	<p>It is the intent of this facility to maintain physical plant to meet State and Federal guide lines</p> <p>The doors in question have been adjusted, replaced or repaired All residents have the potential to be affected no Residents have to been found to be affected by this sighting Preventive Maintenance Logs have been established to monitor the conditions of facility doors The Maintenance Man will check 10 doors weekly for 3 months then check 10 doors monthly on going to verify or identify any doors needing adjusting or repaired these findings will be recorded on maintenance logs and reviewed as needed at Monthly QA meeting</p>	01/14/2016

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K 0038 SS=F Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observations and interview, the facility failed to ensure 2 of 2 first floor stairway exits which continued more than one-half story beyond the level of exit discharge, were interrupted at the level of exit discharge by partitions, doors, or other effective means. LSC 7.7.3 requires the exit discharge shall be arranged and marked to make clear the direction of egress to a public way. Stairs shall be arranged so as to make clear the direction of egress to a public way. Stairs that continue more than one-half story beyond the level of exit discharge shall be interrupted at the level of exit discharge by partitions, doors, or other effective means. This deficient practice could affect all residents in the facility that would use the first floor north and south stairway exits during an evacuation.</p> <p>Findings include:</p> <p>Based on observations on 12/15/15</p>	K 0038	<p>It is the intent of the facility to ensure that public egress to the exits are properly marked to give clear direction, and that the public has a barrier to keep them from going further than the first floor exit All residents have the potential to be affected no Residents have to been found to be affected by this sighting A barrier has been placed in both stairwells the public to not go further than the first floor stairs The barrier will be checked daily for 4 weeks by the maintenance man then weekly from that time forward. Signs will be placed to notify the public that they are not allowed lower than the first floor The findings will be recorded in the maintenance logs and reviewed at QA meetings as needed.</p>	01/14/2016

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K 0046 SS=E Bldg. 01	<p>during a tour of the first floor north and south stairway exits with the maintenance supervisor from 2:10 p.m. to 2:20 p.m., the first floor and second floor stairway exits discharged onto concrete sidewalk surfaces and exited into the rear parking lot. Furthermore, the two first floor stairway exits continued to the basement and lacked stairway interrupters at the first floor level of discharge. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 12/15/15 at 2:50 p.m.</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. Based on observation and interview, the facility failed to ensure 2 of 2 battery backup lights were tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system</p>	K 0046	<p>It is the intent of this facility to Maintain a PML to ensure battery backups are checked routinely and are in good repair All residents have the potential to be affected no Residents have to been found to be affected by this sighting Preventive Maintenance Logs have been established to monitor the emergency lighting battery backup power source for Monthly checks and then one 90 minute load test annually The</p>	01/14/2016

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	<p>at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect 12 residents who use the first floor therapy room in the event of the battery backup light failure in the emergency generator room during periods of power outages.</p> <p>Findings include:</p> <p>Based on observation on 12/15/15 during a tour of the first floor therapy room and adjoining business office with the maintenance supervisor from 11:15 a.m. to 11:50 a.m., the therapy room and the business office each had a battery backup light located above the exit doors.</p> <p>Based on an interview with the maintenance supervisor on 12/15/15 at the time of observation, the maintenance supervisor indicated the facility did not test the two battery backup lights monthly or conduct an annual ninety minute test. The lack of monthly testing and annual ninety minute tests on two battery backup lights was verified by the</p>		<p>Maintenance Man will check all battery backup power source weekly for 4 weeks then check battery backup power source monthly on going to verify or identify any batteries needing replaced. A 90 minute load test will be done annually and recorded on PM logs and the logs will be reviewed at monthly QA meeting as needed</p>	

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K 0050 SS=F Bldg. 01	<p>maintenance supervisor at the time of interview acknowledged by the administrator at the exit conference on 12/15/15 at 2:50 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills on 1 of 3 shifts and 2 of 4 quarters over the past year and failed to list the time on 2 of 10 fire drills conducted over the past year. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Monthly Fire Drill Records with the maintenance supervisor on 12/15/15 at 9:10 a.m., there was no fire drill record for the third shift, second quarter of the year 2015 and third shift, third quarter for the year 2015.</p>	K 0050	<p>It is the intent of the facility to maintain required documents of required testing of the facility Fire drills All residents have the potential to be affected, no Residents have to been found to be effected by this sighting Fire Drills will be done on each shift once a month at varied times and will simulate different circumstances and recorded of what the Drill simulation was and who responded at what time and record the findings.</p> <p>Fire Drills will be done on each shift once a month at varied times and will simulate different circumstances and recorded of what the Drill simulation was and who responded at what time and record the findings. Finding will</p>	01/14/2016

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K 0056 SS=E Bldg. 01	<p>Additionally, the fire drill conducted on 10/30/15 failed to list the time and only reflected third shift and the fire drill conducted on 01/23/15 failed to list the time and only reflected first shift. This was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 12/15/15 at 2:50 p.m.</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 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 2 of 2 combustible overhang porches exceeding four feet were provided with sprinkler coverage. NFPA 13, 5-13.8.1 requires sprinklers shall be installed under exterior combustible roofs or canopies</p>	K 0056	<p>be recorded and reviewed each month at QA meeting and reviewed for problems The maintenance man will be responsible for maintaining the Fire Drill Logs</p> <p>It is the intent of the facility to ensure that sprinklers are installed in all places required to meet state and federal rules All residents have the potential to be affected no Residents have to been found to be affected by this sighting Sprinkler system will be put into place as required by 14</p>	01/14/2016

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K 0062 SS=E Bldg. 01	<p>exceeding four feet in width. This deficient practice affects 14 residents who reside on the first floor and would use the first floor east exit during an evacuation.</p> <p>Findings include:</p> <p>Based on observations on 12/15/15 at 10:55 a.m. with the maintenance supervisor, the first floor front exit outside front porch overhang, which measured thirty six foot by eight foot and the first floor business office exit outside porch overhang, which measured ten foot by nine foot, were not provided with sprinkler coverage. Based on observation of the porch construction with the maintenance supervisor and interview on 12/15/15 at 11:10 a.m., it was stated the porches are constructed of wooden rafters and plywood siding and do not have a fire separation where the porches are constructed onto the facility. This was acknowledged by the administrator at the exit conference on 12/15/15 at 2:50 p.m.</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,</p>		<p>January 2016 These sprinkler heads will be checked by sprinkler company upon there quarterly schedule and also annual per requirements</p>				

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	<p>NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to replace 1 of over 300 sprinklers in the facility covered in paint. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 2 residents reside in resident room 101.</p> <p>Findings include:</p> <p>Based on observation on 12/15/15 at 11:15 a.m. with the maintenance supervisor, resident room 101 bathroom sprinkler was completely covered in yellow paint. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 12/15/15 at 2:50 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 5 of over 300 sprinkler heads in the facility were</p>	K 0062	<p>It is the intent of the facility to replace any sprinklers found In need of replacement due to paint or other working issues All residents have the potential to be affected no Residents have to been found to be affected by this sighting All sprinklers sighted have been replaced The maintaining sprinkler company has been informed that during there inspections any sprinkler needed replaced should be done The maintenance man will review 10 sprinkler heads weekly for 4 weeks then 10 monthly for 3 months, then any other time painting is done the sprinklers will be protected from paint splatter or replaced if needed.</p> <p>The maintenance man will maintain the audits of the inspections</p>	01/14/2016			

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K 0069 SS=F Bldg. 01	<p>maintained. This deficient practice could affect 3 residents at a time who use the beauty shop.</p> <p>Findings include:</p> <p>Based on observations on 12/15/15 during a tour of the facility from 9:55 a.m. to 2:45 p.m. with the maintenance supervisor, the basement public restroom sprinkler, the beauty shop sprinkler, and the business office three sprinklers were each lacked escutcheons. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 12/15/15 at 2:50 p.m.</p> <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 record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was cleaned at least semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated</p>	K 0069	<p>It is the intent of this facility to maintain the kitchen exhaust systems in a clean and proper working condition All residents have the potential to be affected no Residents have to be found to be effected by this sighting The exhaust cleaning company has been contacted and records requested for the last year, and exhaust system has been scheduled for cleaning prior to 14</p>	01/14/2016

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	<p>with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1 requires systems serving moderate volume cooking operations shall be inspected semiannually. This deficient practice could affect all resident in the facility.</p> <p>Findings include:</p> <p>Based on record review on 12/15/15 at 9:25 a.m. with the maintenance supervisor, the most recent kitchen exhaust cleaning record available for review was dated 02/01/15. Based on an interview with the maintenance supervisor on 12/15/15 at 9:30 a.m., it was indicated there is no other records available to indicate a semiannual hood cleaning was conducted after 02/01/15. The lack of semiannual kitchen exhaust cleaning for the most recent semiannual time frame was verified by the maintenance supervisor at the time of record review and interview and acknowledged by the administrator at the exit conference on 12/15/15 at 2:50 p.m.</p> <p>3.1-19(b)</p>		<p>January 2016 These records will be maintained by the maintenance and reviewed on a semiannual bases during that quarters QA meeting</p>	

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K 0071 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes:</p> <p>(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5.</p> <p>(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7.</p> <p>(3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4.</p> <p>(4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 laundry chute was provided with latching hardware to allow the linen chute door to self close and latch into the door frame. This deficient practice could affect all staff who work in the basement.</p> <p>Findings include:</p>	K 0071	<p>It is the intent of this facility to ensure that the laundry chute are well maintained and in good working order</p> <p>All residents have the potential to be affected no Residents have to been found to be effected by this sighting</p> <p>Laundry chute has been repaired and is in good working order</p> <p>Laundry chute doors will be checked weekly for 4 weeks then</p>	01/14/2016

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K 0130 SS=E Bldg. 01	<p>Based on observation with the maintenance supervisor on 12/15/15 at 10:15 a.m., the basement laundry chute door failed to close and latch into the door frame on three separate attempts. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 12/15/14 at 2:50 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation, record review and interview, the facility failed to ensure 3 of 3 boilers had an inspection certificate that was current to ensure the boilers was in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all staff in the facility who work in the basement.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 12/15/15 at 11:00 a.m., the American model hot water heater located in the basement</p>	K 0130	<p>monthly on going, The maintenance man will record the inspection of laundry chutes and maintain repair records if any issues are found the findings will be reviewed at monthly QA meeting</p> <p>I is the intent of this facility to maintain boilers in operational conditions and to ensure that boilers are inspected to ensure the boilers are in safe operating condition All residents have the potential to be affected no Residents have to been found to be effected by this sighting Boiler Inspection company has been notified and records have been requested for past inspections and a current inspection is scheduled to be done prior to 14 Jan 2016 if one can not be found within the last year. These records will be maintained by the maintenance man with a copy to be maintained in the administrators office.</p>	01/14/2016

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K 0144 SS=F Bldg. 01	<p>laundry room, and the A O Smith model hot water heater and Bradford White model hot water heater located in the basement mechanical room, each had an inspection certificate mounted in a frame on the wall in the laundry and mechanical rooms with an expiration date of 10/18/15. Based on an interview with the maintenance supervisor on 12/15/15 at 11:10 a.m., it was stated there are no current two year inspection certificates for the three hot water heaters. The lack of current inspection certificates for the three hot water heaters was acknowledged by the administrator at the exit conference on 12/15/15 at 2:50 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generator was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which</p>	K 0144	<p>It is the intent of this facility to ensure that a monthly load test are done for the emergency generator and that a full load test is done annually for 90 minutes All residents have the potential to be affected no Residents have to been found to be affected by this sighting Audit tool has been set up for monthly load test and a full load</p>	01/14/2016

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	<p>maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on an interview with the maintenance supervisor on 12/15/15 at 9:20 a.m., the only records available for review for the emergency generator were Emergency Generator-Weekly Inspection Checklists. Furthermore, the maintenance supervisor indicated the monthly load test log for the past year</p>		<p>test for 90 minutes will be done by 14 January 2016 The maintenance man will maintain these test in his PM log and have available for review Generator test will be review monthly in QA meeting for 3 months then reviewed quarterly there after for compliance</p>				

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K 0147 SS=E Bldg. 01	<p>could not be found after the last maintenance supervisor left employment. The lack of the monthly load tests for the emergency generator was verified by the maintenance supervisor at the time of record review and interview, and acknowledged by the administrator at the exit conference on 12/15/15 at 2:50 p.m.</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, the facility failed to ensure extension cords were not used as a substitute for fixed wiring in 2 of 21 basement room. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 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 practice affects all staff in the facility who work in the basement.</p> <p>Findings include:</p> <p>Based on observations on 12/15/15 during a tour of the basement with the</p>	K 0147	<p>It is the intent of this facility to not use extension cords as a substitute for fixed wiring All residents have the potential to be affected no Residents have to been found to be effected by this sighting all unauthorized extension cords have been taken out of service</p> <p>The maintenance man will inspect 10 random rooms weekly for 4 weeks and then inspect 10 random rooms monthly from then on, looking for unauthorized use of extension cords any unauthorized extension cords found will be taken out of service.</p>	01/14/2016

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K 0154 SS=F Bldg. 01	<p>maintenance supervisor, the kitchen had an extension cord used to power a chest freezer and the nursing office had an extension cord used to power a copier machine. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 12/15/15 at 2:50 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, standard for Inspection, Testing and maintenance of water-Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5</p>	K 0154	<p>It is the intent of the facility to provide a written policy in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period All residents have the potential to be affected no Residents have to been found to be affected by this sighting Disaster Manual was located after survey and a copy is enclosed for your review Disaster Manual will be reviewed monthly for 3 months, and if issues are found the manual will be brought to monthly QA meeting for review, If no problems noted the Manual</p>	01/14/2016

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K 0155 SS=F Bldg. 01	<p>requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned and lastly 11-7 requires notification of everyone again when the system is restored. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on a review of the Impairment Policy for the Sprinkler System dated January 2015 with the maintenance supervisor on 12/15/15 at 9:45 a.m., the written plan lacked notification of the Indiana State Department of Health, the local fire department, and the insurance carrier. This was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 12/15/15 at 2:50 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of</p>		will be reviewed Quarterly at QA meeting. Audit form will be maintained and signed of by maintenance man that manual has been reviewed		

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	<p>service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to ensure its written fire watch policy addressed all procedures to be followed in this facility in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 to protect 38 of 38 residents. This deficient practice could affect all residents in the health care portion of the facility.</p> <p>Findings include:</p> <p>Based on a review of the Fire Disaster Plan on 12/15/15 at 9:50 a.m. with the maintenance supervisor, there was no written fire watch policy in the event the fire alarm system had to be placed out of service for four hours or more in a twenty four hour period. This was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 12/15/15 at 2:50 p.m.</p> <p>3.1-19(b)</p>	K 0155	<p>It is the intent of this facility to ensure that a written fire watch policy is in place All residents have the potential to be affected no Residents have to been found to be affected by this sighting The distaster Manual was located after the survey and the fire watch policy is in place The Fire watch policy will be reviewed monthly by maintenance man and at QA meeting for 3 months then Quarterly after to ensure there are no need for changes and to assure policy is current with Life Safety requirements</p>	01/14/2016