

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155699	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/10/2016
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NAME OF PROVIDER OR SUPPLIER BRIDGEWATER REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 715 N MILL ST HARTFORD CITY, IN 47348
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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: 05/10/16</p> <p>Facility Number: 000290 Provider Number: 155699 AIM Number: 100379970</p> <p>At this Life Safety Code survey, Bridgewater Rehabilitation Centre 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. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard wired smoke detection in 15 resident rooms on 200 hall and battery powered smoke alarms in 25 resident</p>	K 0000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider or any conclusion set forth in the state of deficiencies or any violation of regulation. Provider desires that the 2567 plan of correction be considered the letter of credible compliance and requests that our date of compliance is on or after June 9, 2016.</p> <p>Respectfully submitted, James M. Combs, MBA/HFA Administrator</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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K 0018 SS=E Bldg. 01	<p>rooms on 100 hall. The facility has a capacity of 78 and had a census of 23 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed on 05/11/16 - 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 shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 18 resident room corridor doors on the 100 hall</p>	K 0018	<p>K018</p> <p>The corridor door to Resident Room 103 has been repaired by</p>	06/09/2016

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K 0025 SS=E Bldg. 01	<p>closed and latched into the door frame. This deficient practice could affect any of the 25 residents on the 100 hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 05/10/16 at 11:01 a.m., the corridor door to resident room 103 failed to latch into the door frame. Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance</p>	K 0025	<p>theMaintenance Supervisor on 05/20/2016.</p> <p>All corridor doors to Resident Rooms have been inspected and alldoors latch into the door frame.</p> <p>Maintenance Supervisor or designee will complete weekly corridorResident Room audits indefinitely to ensure all corridor doors latch into doorframes. These audits will then be turned into the Quality Assurance Committeefor review. Any deficient practice identified during the audits will becorrected immediately.</p> <p>1.The smoke barrier wall by the service hall was sealed with sheetrock and fire rated fire caulking on 05/20/2016 by the Maintenance Supervisor 2.The smoke barrier wall by the respiratory office was sealed withsheet rock and fire rated fire</p>	06/09/2016

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	<p>with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect up to 25 residents in 4 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 5/10/16 from 10:00 a.m. to 12:25 p.m., the following smoke barrier walls had unsealed penetrations:</p> <p>a) Above the ceiling tiles of the smoke barrier wall by the service hall there was an unsealed fourth of an inch crack six feet in length between the wall and ceiling.</p> <p>b) Above the ceiling tiles of the smoke barrier wall by repertory there was an unsealed fourth of an inch crack six feet in length between the wall and ceiling.</p> <p>c) Above the ceiling tiles of the smoke barrier wall by therapy there were two unsealed fourth of an inch penetrations around a wires.</p> <p>d) In the attic of the smoke wall by</p>		<p>caulking on 05/20/2016 by the MaintenanceSupervisor</p> <p>3.The smoke barrier wall by therapy room was sealed with a firerated fire caulking on 05/20/2016 by the Maintenance Supervisor</p> <p>4.The smoke wall in the attic by the respiratory office allpenetrations were sealed with fire rated fire caulking on 05/20/2016 by theMaintenance Supervisor</p> <p>A facility wide inspection was conducted by the MaintenanceSupervisor on 05/20/2016 to ensure no other penetrations or cracks werepresent. No other areas of concern were identified at the time of theinspection.</p> <p>Maintenance Supervisor or designee will complete monthlyinspections indefinitely to ensure fire caulking remains in place and that nocracks or dry rot has occurred. The findings from these inspections will be returned in and reviewed during the facilities monthly Quality AssuranceCommittee meetings. Any deficient practice identified during the audits will becorrected immediately.</p>	

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K 0027 SS=E Bldg. 01	<p>repertory there were two unsealed one inch penetrations around pipes. Based on interview at the time of observation, the Maintenance Supervisor acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-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 Based on observation and interview, the facility failed to ensure 1 of 5 smoke barrier doors were providing a fire resistance of at least 20 minutes, this deficient practice could affects up to 15 residents in the dining room</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor and the Administrator on 05/10/16 at 10:50 a.m., the double set of smoke barrier doors to the dining room had the label painted and the fire rating could not</p>	K 0027	<p>K027</p> <p>The dining room smoke barrier doors had the paint removed from the fire rating making the label visible by the Maintenance Supervisor on 05/20/2016.</p> <p>A facility wide inspection of all smoke doors/fire doors was conducted on 05/20/2016 by the Maintenance Supervisor and found no further labels painted.</p> <p>Maintenance Supervisor or designee will complete annually, inspections of each set of fire/smoke doors to ensure</p>	06/09/2016

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K 0029 SS=E Bldg. 01	<p>be determined. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the painted label, and could not provide other documentation of the smoke doors fire rating.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 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>1. Based on observation and interview, the facility failed 3 of 8 hazardous areas were smoke resistive. This deficient practice could affect 25 residents in 3 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation and interview during the tour with the Maintenance supervisor on 5/10/16 between 10:00 a.m. and 12:00 p.m. the following</p>	K 0029	<p>labels remain unpainted and in place. Findings from these inspections will be turned into the Quality Assurance Committee for review; any deficient practice identified will be corrected immediately.</p> <p>K029</p> <p>1. The mechanical room on 200 hall had all penetrations sealed with a fire rated fire caulking. 2. In the mechanical room in the service corridor hall, all 5 penetrations with wires were sealed using fire rated fire caulking. 3. In the laundry room behind the dryers, all 3 penetrations were sealed with fire rated fire caulking. 4. 2 of 2 storage rooms on the</p>	06/09/2016

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	<p>hazardous area had unsealed penetrations:</p> <p>(a) In the mechanical room on the 200 hall which contained a fuel fired water heater had a half inch penetration around wires.</p> <p>(b) In the mechanical room on the service hall which contained a fuel fired water heater had five unsealed one and a half inch penetrations around wires.</p> <p>(c) In the laundry room behind the fuel fired dryers had three unsealed half inch penetrations around pipes.</p> <p>Based on interview at the time of observation the Maintenance acknowledge and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor door to 2 of 2 storage rooms with combustibles, measuring over 50 square feet in size, were provided with a self-closing device. This deficient practice could affect 25 residents on the 100 hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 06/10/16 from 10:45 a.m. to 11:20 a.m., the</p>		<p>100 hall had automatic door closure installed by the Maintenance Supervisor on 05/20/2016.</p> <p>5. Record room that contained 15 plastic tubs had an automatic door closure installed by the Maintenance Supervisor on 05/20/2016.</p> <p>6. The Maintenance office had an automatic door closure installed on 05/20/2016 by the Maintenance Supervisor.</p> <p>7. The 1 of 2 kitchen doors had a door closure installed on 05/20/2016 by the Maintenance Supervisor.</p> <p>A facility wide inspection was conducted by the Maintenance Supervisor on 05/20/2016 to ensure no other penetrations or cracks were present. No other areas of concern were identified at the time of the inspection.</p> <p>A facility wide inspection was conducted by the Maintenance Supervisor on 05/20/2016 to ensure no other door had a missing door closing system installed. No other areas were identified at the time of the inspection.</p> <p>Maintenance Supervisor or designee will complete monthly inspections indefinitely to ensure fire caulking remains in place and that no cracks or dry rot has occurred. The findings from</p>		

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	<p>corridor door to the following rooms with combustibile storage, measuring over 50 square feet in size, lacked a self-closing device:</p> <p>a) Record storage room containing 15 plastic tubs of paper work.</p> <p>b) The Maintenance office containing 10 cardboard boxes of supplies, a pile of tarps, and other combustibile supplies. Based on interview, this was confirmed by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 2 kitchen doors automatically close and latched into the door frame. This deficient practice was not in a resident care area but could affect staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance supervisor on 05/10/16 at 12:24 p.m., the door going in a form the service corridor to the kitchen through the dry storage did not automatically latch into the door frame due a lack of a self-closing device. Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observation.</p>		<p>these inspections will returned in and reviewed during the facilities monthly Quality Assurance Committee meetings. Any deficient practice identified during the audits will becorrected immediately.</p> <p>Maintenance Supervisor or designee will complete annualinspections indefinitely to ensure door closures remain in place and functionappropriately. The results on these inspections will be submitted to theQuality Assurance Committee for review, any deficient practice will becorrected immediately.</p>	

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K 0038 SS=E 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>1. Based on observation and interview, the facility failed to ensure 2 of 6 exit discharge paths was readily accessible at all times. LSC Section 7.1 requires means of egress for buildings shall comply with Chapter 7. LSC Section 7.2.5.4 requires a ramp with a rise greater than 6 inches shall have handrails. LSC Section 7.2.2.4.2 Exception #3 states existing ramps shall be permitted to have a handrail on one side only. This deficient practice could affect 25 residents evacuating through the therapy exit and the 100 hall exit in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 05/10/16 between 10:10 a.m. to 11:15 p.m., near the bottom of the 100 hall exit discharge sidewalk/ramp the handrail was loose and wobbly due to the post being loose in the mud. Additionally, the therapy exit discharge sidewalk/ramp the handrail was loose and wobbled due to</p>	K 0038	<p>K038</p> <p>Both exit handrails on the 100 hallway were securely fastened to the pavement and/or placed in concrete by the Maintenance Supervisor on 05/27/2016. Both handrails are no longer loose or wobbly.</p> <p>All other exit handrails were checked and are appropriately fastened or secured in a way that will prevent them from becoming loose or wobbly.</p> <p>The linen cart that was stored in the corridor was moved to its new location behind the nurse's station permanently.</p> <p>The Administrator or designee will complete daily monitoring for 30 days to ensure the cart is appropriately stored behind the nurse's station. This monitoring will continue for 90-days thereafter. The results of these findings will be submitted to the Quality Assurance Committee for review and if any deficient practice is identified it will be corrected immediately.</p>	06/09/2016

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	<p>the mounts in the pavement being loose. Based on an interview with the Maintenance Director at the time of observation, the supports at the sidewalk of the handrail were broken making the handrail leaning to one side.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 4 exit access corridors was readily accessible and unobstructed at all times. This deficient practice could affect 14 residents using the therapy exit.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor and Administrator on 05/10/16 at 10:10 a.m. and again at 12:05 p.m., a clean linen cart was stored in the therapy corridor from 10:10 a.m. to 12:05 p.m. Based on an interview at the time of observations, the Administrator stated it was in the corridor due to the remodeling take place in the facility, and the place it is normally stored now contained records.</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 include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills for third shift at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Fire Drill Record" forms with the Maintenance Supervisor on 05/10/16 at 9:18 a.m., all third shift fire drills took place between 10:00 p.m. and 11:50 p.m. for the last four quarters. Based on interview, this was confirmed by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p>	K 0050	<p>K050</p> <p>It is to be noted, that fire drills were completed for the entire last 4 quarters.</p> <p>The Maintenance Supervisor and Administrator were re-educated on fire drills and scheduling fire drills on 05/17/2016 by the Regional Director of Operations.</p> <p>Fire drill will be conducted according to the schedule and results of the fire drills will be submitted to the Administrator for his/her review any fire drill conducted out of the schedule will be redone immediately. (SEE ATTACHMENT A)</p>	06/09/2016

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K 0062 SS=E Bldg. 01	<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 ensure the spray pattern for 2 of 12 sprinkler heads was unobstructed in the lobby. LSC 9.7.5 requires all automatic sprinkler systems 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, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice could affect 10 resident in the lobby.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor and Administrator on 05/10/16 at 12:01 p.m., there were two sprinkler heads above the drop ceiling in the lobby. Based on interview at the time of observation, the Maintenance Supervisor stated the lobby drop ceiling was just added and the sprinkler heads were going to be dropped by the facility's sprinkler company.</p>	K 0062	<p>K062</p> <p>Both sprinkler heads identified in the 2567 has since beenreplaced on 05/17/2016 by Elwood Fire & Equipment Company.</p> <p>A facility wide inspection was completed by the MaintenanceSupervisor on 05/10/2016 and found no further sprinkler heads missing.</p>	06/09/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155699	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/10/2016
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K 0066 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to ensure 1 of 2 smoking areas were properly maintained and provided with a self-closing trash receptacle used to empty ashtrays only. This deficient practice could affect up to 15 residents using the dining room exit.</p>	K 0066	<p>K066</p> <p>The trash in the self closing container was immediately removed bythe Administrator and Maintenance Supervisor on 05/10/2016</p> <p>All staff was re-educated on 05/20/2016 on not having any</p>	06/09/2016

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K 0067 SS=F Bldg. 01	<p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 05/10/16 at 11:00 p.m., in the smoking area near the dining room exit contained a self-closing trash receptacle containing cigarette Butts and combustible trash. Base on interview at the time of observation, the Maintenance supervisor acknowledged the metal container with a self-closing lid contained trash.</p> <p>3.1-19(b)</p> <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 record review, observation, and interview, the facility failed to provide 1 of 1 fire damper inspections to show dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999</p>	K 0067	<p>trashmixed in with the self closing container dedicated for cigarette butts only</p> <p>Administrator or designee will complete daily inspections weeklyfor 8 weeks to ensure no trash is being mixed with the cigarette butts. Theseinspections will continue bi-weekly for 4 weeks then monthly thereafter. Therresults of these inspections will be turned into the Quality AssuranceCommittee for review; any deficient practice will be corrected immediately.</p> <p>K067</p> <p>The facility has contacted Elwood Fire & Equipment Company toinspect the fire dampers and has been scheduled for inspection on June 9, 2016. (SEEATTACHMENT B)</p> <p>The Maintenance Supervisor and Administrator were re-educated onthe inspection of fire dampers on 05/20/2016 by the Regional Director ofOperations.</p>	06/09/2016

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K 0147 SS=E Bldg. 01	<p>Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all occupants in the facility.</p> <p>Findings include:</p> <p>Based on record review on with the Maintenance Supervisor on 05/10/16 at 19:30 a.m., no inspection records were available for review for any of the facility's fire dampers. Based on interview during records review, the Maintenance Supervisor stated the facility had dampers, but did not know when the last inspection was conducted and there were no other records available to show completed maintenance on the facility's fire dampers.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation, the facility failed to ensure 1 of 4 electrical outlets in the main lobby was maintained in a safe</p>	K 0147	<p>Once inspection has been completed these results will be kept and maintained for future reference. Any inspection found to have not been completed will be corrected immediately and Elwood Fire & Equipment notified immediately.</p> <p>K147 The electrical outlet that was identified on the facility tour</p>	06/09/2016			

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	<p>operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could 14 residents in the lobby.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Administrator on 05/10/16 at 10:54 a.m., on the wall in the lobby there was an electrical outlet with numerous wire connections jutting out of the box without a cover. Based on an interview at the time of observation, the Administrator acknowledged the electrical junction box was without a cover.</p> <p>3.1-19(b)</p>		<p>wascovered immediately by the Maintenance Supervisor on 05/10/2016.</p> <p>A facility wide inspection was completed on 05/10/2016 andidentified one other outlet missing a cover. This was immediately corrected andcover installed for this outlet that was identified. No other covers wereidentified as missing at this time of inspection.</p> <p>The Maintenance Supervisor or designee will complete monthlyrounds to ensure all outlet covers are in place. The findings of theseinspections will be submitted to the Quality Assurance Committee for review.Any deficient practice identified during these inspections will be correctedimmediately.</p>	