

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2016
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NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260
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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
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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: 08/29/2016</p> <p>Facility Number: 000074 Provider Number: 155154 AIM Number: 100290050</p> <p>At this Life Safety Code survey, Spring Mill Meadows 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 two story facility with a basement was determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 130</p>	K 0000	The following Plan of Correction constitutes our written allegation of compliance for the deficiency cited Submission of this Plan of Correction is not an admission that the deficiency exists or that one was cited correctly This Plan of Correction is submitted to meet the requirements established by State and Federal law This facility requests paper compliance for the deficiencies cited	
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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 0020 SS=F Bldg. 01	<p>and had a census of 114 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached storage shed providing facility storage services which was not sprinklered.</p> <p>Quality Review completed on 09/02/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1</p> <p>Based on observation and interview, the facility failed to ensure 4 of 5 stairways doors were enclosed with one hour construction due to painting over the fire rating tag on the doors and door frames. This deficient practice could affect all residents, visitors, and staff in or near these stairways in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 8/29/16 between 11:25 p.m. and 3:35 p.m.,</p>	K 0020	<p>1) The paint on the fire rating tags on the northeast, northwest, west central stairwells on the first and second floor have been thinned and stripped and now show the fire ratings 2) All residents have the potential to be affected by this alleged deficient practice All fire rated doors have been checked to ensure tags have not been painted 3) Maintenance Director will be inserviced on ensuring fire rating tags are not painted by 9/28/16 4) Maintenance Director will audit all fire doors weekly for four weeks and quarterly thereafter Audits will be reviewed in QA Committee for twelve months</p>	09/28/2016

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K 0022 SS=E Bldg. 01	<p>stairway doors at the following locations had been repainted and the fire rating tags could not be read at:</p> <p>a) the North east stairwell on the first floor</p> <p>b) the North west stairwell on the first floor</p> <p>c) the West central stairwell on the first floor</p> <p>d) the West central stairwell on the second floor</p> <p>At the time of observations, the maintenance supervisor acknowledged that the doors had been recently repainted and the fire rating tags were unreadable.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 8 paths of egress was marked with an approved sign</p>	K 0022	1) The exit sign in Auguste's Cottage now reflects the proper direction to indicate the nearest	09/28/2016	

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	<p>to make the direction of travel to reach the nearest exit apparent. LSC 7.10.1.2 requires exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. This deficient practice affects any resident in the main dining room or in the corridor that extends from the main dining room to the front entrance.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the maintenance supervisor on 08/29/16 at 12:52 p.m., the corridor inside the Cottage unit did not have exit sign that would clearly indicate the direction of exit travel. The exit sign above the exit door that was provided had both chevrons punched out indicating a left or right path of travel, but the locked-down unit exit door was directly ahead. Based on interview at the time of observation, the maintenance supervisor acknowledged that any person coming toward the unit exit could be confused as to where to go to reach the nearest exit based on the sign.</p> <p>3.1-19(b)</p>		<p>exit</p> <p>2) All Auguste's Cottage residents have the potential to be affected by this alleged deficient practice All exit signs have been checked and corrected indicate proper direction of the nearest exit</p> <p>3) Maintenance Director will be inserviced on the proper exit signage by 9/28/16</p> <p>4) Maintenance Director will audit all exit signage weekly for four weeks and quarterly thereafter Audits will be reviewed in QA Committee for twelve months</p>	

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K 0025 SS=D Bldg. 01	<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 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor during the tour at 2:06 p.m. on 08/29/16, there were three small four inch by twelve inch ceiling tiles missing in the second floor I.T. room ceiling. Based on interview with</p>	K 0025	<p>1) The ceiling tiles in the second floor IT room have been replaced 2) No residents, however, all staff have the potential to be affected by this alleged deficient practice 3) Maintenance Director will be inserviced on ensuring ceiling tiles are being replaced after repairs are made by 9/28/16 4) Maintenance Director will audit the facility for any missing tiles weekly for four weeks and ongoing thereafter Audits will be reviewed in QA Committee for twelve months</p>	09/28/2016

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K 0027 SS=E Bldg. 01	<p>the maintenance supervisor at the time of the observation, he acknowledged the missing ceiling tiles.</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 3 of 4 sets of smoke barrier doors on the second floor would close to form a smoke resistant barrier. This deficient practice could affect as many as 40 residents as well as staff and visitors up on the second floor.</p>	K 0027	<p>1 The southeast, northeast, and southwest corridor smoke barrier door coordinators were readjusted to close properly</p> <p>2 All second floor residents have the potential to be affected by this alleged deficient practice</p> <p>3 Maintenance Director will be inserviced on ensuring there are no gaps between smoke barrier doors by 9/28/16 Maintenance</p>	09/28/2016
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K 0029 SS=D Bldg. 01	<p>Findings include:</p> <p>Based on observation with the maintenance supervisor during a tour of the facility from 11:30 p.m. to 3:35 p.m. on 08/29/16, the set of smoke barrier doors in:</p> <p>(a) the South East corridor near resident room 236 had a four inch gap (b) the North East corridor near resident room 222 had a six inch gap (c) the South West corridor near resident room 204 had a six inch gap</p> <p>These doors would not close properly because the door coordinator was not functioning. Based on interview at the time of observation, the maintenance supervisor stated the smoke barrier door set did not close completely because the door closing coordinator was broken and failed to ensure the door equipped with an astragal closes last.</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</p>		Director will audit all smoke barrier doors to ensure gaps are not present 4 Maintenance Director will audit all smoke barrier doors weekly for four weeks and ongoing thereafter Audits will be reviewed in QA Committee for twelve months		

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	<p>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 to ensure the corridor doors to 1 of 12 hazardous areas, such as a medical records and file storage area, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect any employee or employees and staff in the basement area.</p> <p>Findings include:</p> <p>Based on observation on 8/29/16 at 1:15 p.m. with the maintenance supervisor, the medical records door, located within the basement, lacked a self closing device. This was verified by the maintenance supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2) Based on observation and interview, the facility failed to ensure 2 of 12 hazardous areas;</p> <p>a) the medical records storage located in the basement because it contained ten one</p>	K 0029	<p>1) A self-closing device was installed on the medical records office door Vent/partition has been removed and closed off</p> <p>2) No residents, however, six employees have the potential to be affected by this alleged deficient practice</p> <p>3) Maintenance Director will be inserviced on self-closure and smoke barrier partition requirements by 9/28/16 Maintenance Director will audit all doors and smoke barrier partitions to meet the NFPA 8841 and 19354 requirements weekly for four weeks and ongoing thereafter Audits will be reviewed in QA Committee for twelve months</p>	09/28/2016

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K 0038 SS=D Bldg. 01	<p>foot by four feet boxes of medical records and had six two feet by four feet open top tubs of loose medical records.</p> <p>b) the housekeeping supervisor's office located in the basement that contained hundreds of sheets, linens, and towels. were separated from the corridor by a partition capable of resisting the passage of smoke. This deficient practice could affect up to 6 employees in the basement area.</p> <p>Findings include:</p> <p>Based on an observation on 8/29/16 at 1:15 p.m. with the maintenance supervisor, both the medical records office and housekeeping supervisor's offices had vents above the door open to the corridor. The one over medical records measuring four inches by six inches, and the one above housekeeping supervisor's office measuring four inches by eight inches. The maintenance supervisor acknowledged and provided measurements for the vents above both aforementioned doors.</p> <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>			
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	<p>Based on observation and interview, the facility failed to ensure 1 of 1 door to the nursing supply room on the second floor was provided with door latches readily operated 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 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 a single action unlatch the door. This deficient practice could affect 2 staff in the supply room.</p> <p>Findings include:</p> <p>Based on observation with maintenance supervisor on 8/29/16 at 1:40 p.m., the nursing supply room corridor door was equipped with an independent dead bolt in addition to the door knob. Based on interview with the maintenance supervisor at the time of observation, he acknowledged the therapy room had an independent dead bolt.</p> <p>3.1-19(b)</p>	K 0038	<p>1) The independent dead bolt on the nursing supply door has been removed The therapy room did not have a dead bolt and knob on the door 2) No residents, however, two employees have the potential to be affected by this alleged deficient practice 3) Maintenance Director will be inserviced to ensure doors do not have a two-step release by 9/28/16 4) Maintenance Director will audit all doors weekly for four weeks and ongoing thereafter Audits will be reviewed in QA Committee for twelve months</p>	09/28/2016			

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K 0056 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>Based on observation and interview, the facility failed to ensure only one type of sprinkler head i.e. quick response or standard sprinklers were installed in one second floor corridor and one connecting lounge area. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a smoke compartment shall be changed. This deficient practice could affect all residents in the main dining room and any number of staff in the Therapy/business exit passageway.</p> <p>Findings include:</p>	K 0056	<p>1) The sprinkler head was replaced with the same sprinkler heads in the corridor lounge area 2) All second floor residents have the potential to be affected by this alleged deficient practice Maintenance Director will audit all facility sprinkler heads 3) Maintenance Director will be inserviced on notification of any change in sprinkler heads to match existing sprinkler heads by 9/28/16 4) Maintenance Director will audit all facility sprinkler heads when changes are needed to ensure the correct sprinkler heads are installed Results of any changes will be reviewed monthly in QA Committee for twelve months</p>	09/28/2016

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K 0062 SS=E Bldg. 01	<p>Based on observations with the maintenance supervisor on 8/29/16 at 1:51 p.m., the second floor east - west corridor and lounge area had what appear to be a mixture of quick response sprinkler heads with the glass rods and standard response fusible link sprinkler heads. Based on an interview with the maintenance supervisor at the time of observations, he confirmed there were indeed different types of sprinkler heads located within the same corridor and interconnected lounge area.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace 1 of 1 sprinklers in the bathroom in resident rooms 100 and 1 of 1 sprinkler head in resident room 102, which had been painted. There were also 2 of 13 sprinkler heads located in the kitchen showing signs of corrosion. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and</p>	K 0062	<p>1) The sprinkler heads located in the bathrooms of Rooms 100 and 102 were replaced as well as the two corroded kitchen sprinkler heads</p> <p>2) The residents in Rooms 100 and 102 have the potential to be affected by this alleged deficient practice The kitchen staff also have the potential to be affected by this alleged deficient practice</p>	09/28/2016
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	<p>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 the residents, staff and visitors in and near rooms 100 and 102.</p> <p>Findings include:</p> <p>Based on observation during a tour with the maintenance supervisor on 8/29/16 between 11:30 a.m. an 3:35 p.m., the following deficiencies were found:</p> <p>a) one sprinkler in the bathroom of resident room 100 had paint on the deflector.</p> <p>b) one sprinkler in the bathroom of resident room 102 had paint on the deflector.</p> <p>c) two sprinkler heads in the kitchen area were green and corroded.</p> <p>The maintenance supervisor acknowledged the paint and the corrosion on all the aforementioned sprinklers at the time they were found.</p> <p>3.1-19(b)</p>		<p>3) Maintenance Director will be inserviced on ensuring sprinkler heads are not painted or corroded by 9/28/16</p> <p>4) Maintenance Director will audit all sprinkler heads when ceiling work has been painted Results of any changes will be reviewed in QA Committee times twelve months</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
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K 0069 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to maintain 1 of 1 kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 1998 edition, Section 3-2.7 states grease filters that require a specific orientation to drain grease shall be clearly designated or the hood shall be constructed so that filters cannot be installed in the wrong direction. This deficient practice could affect three staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor during a tour of the facility at 12:20 p.m. on 8/29/16, the baffle filters in the grease catch in the kitchen range hood system were installed horizontally. Based on interview at the time of observation, the maintenance</p>	K 0069	<p>1) The proper baffle filters have been replaced 2) No residents, however, three employees have the potential to be affected by this alleged deficient practice 3) Maintenance Director will be inserviced on the proper baffle filters for the kitchen range hood system 4) Maintenance Director will audit for proper baffle filters weekly times four weeks and then monthly thereafter Results of any changes will be reviewed in QA monthly times twelve months</p>	09/28/2016
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2016
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K 0072 SS=F Bldg. 01	<p>supervisor acknowledged the baffle filters were installed incorrectly, and would have them changed accordingly.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use for 2 of 2 first floor exits means of egress and 2 of 2 second floor means of egress. This deficient practice could affect 60 residents, as well as staff and visitors.</p> <p>Findings include:</p>	K 0072	<p>1) All items were removed from the corridor and stored in their proper locations</p> <p>2) All residents have the potential to be affected by this alleged deficient practice</p> <p>3) Staff will be inserviced on not blocking means of egress by 9/28/16</p> <p>4) Maintenance Director will audit hallways daily during rounds Audits will be reviewed in QA times twelve months</p>	09/28/2016

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K 0143 SS=E Bldg. 01	<p>Based on observation with the maintenance supervisor during a tour of the facility from 11:30 a.m. to 3:35 p.m. on 8/29/16, there were numerous items being stored at the ends of the hallways. These items included: a four foot by eight foot floor mat and a scale at the end of the west corridor, a chair and a love seat at the end of the east corridor, a chair and a bed frame at the end of the second floor west corridor, and a table and chair at the end of the second floor east corridor. Based on interview at the time of observation, the maintenance supervisor acknowledged all the aforementioned items and stated that they are often placed in the hall areas for storage and are not moved until a later time.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one</p>			
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	<p>container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and</p> <p>(b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.</p> <p>8-6.2.5.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 electric switch in the oxygen storage room on the second floor was located at least five feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage. This deficient practice could affect any residents, staff and visitors in the vicinity of the oxygen storage room.</p> <p>Findings include:</p>	K 0143	<p>1) The electrical outlet was raised to five feet</p> <p>2) Any residents in the vicinity of the oxygen storage room have the potential to be affected by this alleged deficient practice</p> <p>3) Maintenance Director will be inserviced on proper placement of electrical outlets by 9/28/16</p> <p>4) Maintenance Director will audit any new and existing placements of electrical outlets Results of changes will be reviewed in QA Committee times twelve months</p>	09/28/2016

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K 0144 SS=F Bldg. 01	<p>Based on observation with the maintenance supervisor during the tour of the facility at 2:28 p.m. on 8/29/16, there is one electrical outlet on the wall in the second floor oxygen storage room. The electrical outlet was 54 inches above the floor. Based on interview with the maintenance supervisor, it was acknowledged the electrical outlet on the wall was less than five feet above the floor in the second floor oxygen storage room.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. Furthermore, there was no listing for volts or amps on the Emergency Generator monthly testing log. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in</p>	K 0144	<p>1) Due to the checks occurring in the past, the facility could not go back and validate cool down times, volts, or amp information</p> <p>2) All residents have the potential to be affected by this alleged deficient practice</p> <p>3) Maintenance Director will be inserviced on recording the proper information on the monthly generator audit form by 9/28/16</p> <p>4) Maintenance Director will record cool down time, volt, and amp information on the facility's</p>	09/28/2016

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	<p>accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Generator monthly testing log on 8/29/16 at 10:30 a.m. the generator log form documented the generator was tested monthly for 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. There was also no listing for the volts or amps in the generator test log provided. During an interview at the time of record review, the maintenance director confirmed the monthly generator log did not include documentation of a cool down, volts or amps from the generator, but did say he was waiting for a new form that was being provided to him by</p>		generator checks Results will be reviewed in QA Committee times twelve months	

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K 0147 SS=E Bldg. 01	<p>his home office.</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</p> <p>Based on observation, the facility failed to ensure 1 of 1 extension cords, 1 of 1 powerstrips and 1 of 1 non-fused multiplug adapters were not used as a substitute for fixed wiring. 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 would affect approximately 75 of 114 residents.</p> <p>Findings include:</p> <p>Based on observation on 8/29/16 during the tour from 11:30 a.m. to 3:35 p.m. with the maintenance supervisor, the following was noted:</p> <p>a) a coffee pot was plugged into a power</p>	K 0147	<p>1) The surge protector, extension cord, and multi-plug were all removed</p> <p>2) Seventy-five residents have the potential to be affected by this alleged deficient practice</p> <p>3) Staff will be inserviced on the proper procedure for fixed wiring by 9/28/16</p> <p>4) Maintenance Director will audit offices and resident rooms daily times four weeks and weekly thereafter Results will be reviewed in QA Committee times twelve months</p>	09/28/2016
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	<p>strip in the executive director's office</p> <p>b) an extension cord was being used in resident room 109</p> <p>c) non-fused multi-plug was being used in the maintenance supervisor's office / work shop</p> <p>3.1-19(b)</p>				