

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E064	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
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NAME OF PROVIDER OR SUPPLIER  BROOKSIDE HAVEN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N GAVIN ST MUNCIE, IN 47303
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K010000	<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: 10/17/13</p> <p>Facility Number: 000311 Provider Number: 15E064 AIM Number: 100285520</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Brookside Haven Health Care Center was found not in compliance with Requirements for Participation in 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 (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</p>	K010000	<p>K-0000This Plan of Correction is prepared and executed because it is required by the provisions of the State and federal regulations, and not because Brookside Haven agrees with the allegations and citations listed on this statement of deficiencies. This Plan of Correction shall operate as Brookside Haven's written credible allegation of Compliance.</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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	<p>sleeping rooms. The facility has a capacity of 42 and had a census of 40 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/29/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 SS=E	<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 3 of over 40 corridor doors did not have an impediment to closing and latching and would resist the passage of smoke. This deficient practice could affect 18 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 10/17/13, the following was noted:</p> <p>a. the north corridor door to the kitchen from the dining room is a Dutch door and the latching mechanism failed to latch the top door into the door frame after ten attempts. In addition, there is a one inch</p>	K010018	<p>K-0181.) A.)Maintenance Supervisor immediately repaired dutch door to ensure the latching mechanism was functional and in good operating order, also re-adjusted dutch door to ensure resistance of passage of smoke when dutch door set was closed. B.)Maintenance Supervisor immediately re-adjusted south corridor door to ensure door latching into frame when releasing device was activated. C.) Maintenance Supervisor also immediately re-adjusted corridor door to room 15 to ensure the latching mechanism latched into door frame. 2.) Any resident have the potential to be affected.3.) Maintenance Supervisor along with all staff will monitor facility throughout to ensure all corridor doors latch into door frames.</p>	11/15/2013

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	<p>by one half inch rectangular opening between the door frame and the meeting edge of the Dutch door set on the handle side of the Dutch door which failed to resist the passage of smoke when the Dutch door set was closed. The dining room is open to the corridor.</p> <p>b. the south corridor door to the kitchen from the dining room hit the door frame preventing the door from latching into the door frame after five attempts. The aforementioned door is held open by a magnetic releasing device which released the door when the fire alarm system was activated at 2:25 p.m. but the door hit the frame and did not latch into the door frame. The dining room is open to the corridor.</p> <p>c. the latching mechanism for the corridor door to Room 15 failed to latch into the door frame after ten attempts.</p> <p>Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the aforementioned corridor doors each failed to latch into the door frame.</p> <p>3.1-19(b)</p>		<p>Work orders will be completed when doors need adjusting. Maintenance Supervisor will follow policy and procedure to timely correct concerns and report weekly to HFA.4.) Maintenance Supervisor will monitor daily during daily preventive maintenance checks. Maintenance Supervisor will also report to the Q.A. Committee for 6 months to ensure compliance.5.) Date Completed: 11/15/2013</p>		

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>1. Based on observation and interview, the facility failed to ensure ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 18 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 10/17/13, the two inch annular space openings surrounding three one inch in diameter water lines penetrating the ceiling in the Maintenance Housekeeping Office by Room 21 did not provide at least a one half hour fire resistance rating. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned openings in the ceiling smoke barrier did</p>	K010025	K-0251.) A.)Maintenance Supervisor immediately repaired around the three, one inch in diameter water lines penetrating the ceiling in the maintenance/Housekeeping Office to ensure at least a one half hour fire resistance rating. B.) Maintenance Supervisor immediately repaired attic smoke barrier wall to ensure at least a one half hour fire resistance rating.2.) Any resident have the potential to be affected.3.) Maintenance Supervisor will monitor facility throughout (including attic smoke barrier wall) to ensure facility maintains a one half hour fire resistance rating. Will report to HFA any concerns and corrections/repairs will be made timely.4.) Maintenance Supervisor will monitor daily during daily preventive maintenance checks and report to the HFA daily and weekly. Attic smoke barrier walls will be monitored and checked	11/15/2013			

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	<p>not provide at least a one half hour fire resistance rating for the Maintenance Housekeeping Office ceiling smoke barrier.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure ensure 1 of 1 attic smoke barrier walls was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 26 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 10/17/13, the following openings were noted in the attic smoke barrier wall above the corridor door set by Room 11:</p> <p>a. a ten inch long by three inch high hole below the access door to the attic smoke compartment above the resident lounge and dining room.</p> <p>b. the two inch annular space surrounding four, one inch in diameter conduits.</p> <p>Based on interview at the time of the observations, the Maintenance Supervisor acknowledged each of the aforementioned openings in the attic smoke barrier wall did not provide at least a one half hour</p>		<p>upon any repairs in attic. Maintenance Supervisor will also report to the Q.A. Committee for 6 months to ensure compliance.5.) Date Compliance: 11/15/2013</p>				

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	fire resistance rating for the aforementioned attic smoke barrier wall.  3.1-19(b)			

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K010029 SS=E	<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 permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 hazardous areas such as the kitchen was separated from other spaces by smoke resistant partitions and doors which latched securely into their door frames. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 10/17/13, the following was noted:</p> <p>a. the north corridor door to the kitchen from the dining room is a Dutch door. The latching mechanism failed to latch the top door into the door frame after ten attempts which caused a one inch space between the top of the door and the door frame. In addition, there is a one inch by</p>	K010029	K-0291.) A.) Maintenance Supervisor immediately repaired dutch door to ensure the latching mechanism was functional and in good operating order, also re-adjusted dutch door to ensure resistance of passgae of smoke when dutch door set was closed. B.) Maintenance Supervisor immediately re-adjusted south corridor door to ensure door latching into frame when releasing device was activated. C.) Maintenance Supervisor also immediately re-adjusted corridor door to room 15 to ensure the latching mechanism latched into door frame.2.) Any resident have the potential to be affected.3.) Maintenance Supervisor along with all staff will monitor facility throughout to ensure all corridor doors latch into door frames. Work orders will be completed by any staff identifying any concerns.4.) Maintenance	11/15/2013			

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	<p>one half inch rectangular opening between the door frame and the meeting edge of the Dutch door set on the handle side of the Dutch door which would fail to resist the passage of smoke when the Dutch door set was closed.</p> <p>b. the south corridor door to the kitchen from the dining room hit the door frame which caused a one inch opening between the top of the door and the door frame. The aforementioned door is held open by a magnetic releasing device which released the door when the fire alarm system was activated at 2:25 p.m. but the door hit the frame causing a one inch opening between the top of the door and the door frame.</p> <p>Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the aforementioned doors failed to separate the kitchen from other spaces with smoke resistant doors.</p> <p>3.1-19(b)</p>		<p>Supervisor will monitor daily during preventive maintenance checks and report to HFA weekly. Maintenance Supervisor will also report to the Q.A. Committee for 6 months to ensure compliance.5.) Date Completed : 11/15/2013</p>		

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K010038 SS=D	<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 observation and interview, the facility failed to provide 1 of over 40 corridor room doors with not more than one releasing operation. LSC Section 7.2.1.5.4 states a latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches above the finished floor. Doors shall be operable with not more than one releasing operation. Section A.7.2.1.5.4 states examples of devices that might be arranged to release latches include knobs, levers, and panic bars. This deficient practice could affect 1 resident, staff or visitor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 10/17/13, the corridor door to the storage room by the Diet Kitchen room had a door knob and a deadbolt lock on the door. The deadbolt lock required a key to unlock the door from the corridor</p>	K010038	K-0381.) We immediately changed out the deadbolt lock so that it does not require a key to unlock from the inside corridor door to storage room.2.) Any resident have the potential to be affected.3.) Maintenance Supervisor will monitor during daily rounds to ensure continued compliance and report to HFA any concerns.4.) Maintenance Supervisor will report to the Q.A. Committee for 6 months.5.) Date Completed: 11/15/2013	11/15/2013			

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	<p>and from the inside of the aforementioned storage room. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned corridor door required more than one releasing operation to open the door.</p> <p>3-1.19(b)</p>			

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K010039 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 exit access corridors had a clear and unobstructed exit width of at least 4 feet (48 inches). This deficient practice could affect 25 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 10/17/13, one of four upholstered chairs in the main lobby was placed in the means of egress to the main exit by the nurses station. The corridor exit in the main lobby by the nurses station is marked as a facility exit. The clear width with the upholstered chair placed in the means of egress measured three feet.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged the main lobby exit measured less than four feet in clear width.</p> <p>3.1-19(b)</p>	K010039	<p>K-0391.) We immediately moved upholstered chair in the main lobby to ensure egress by nurses station maintains a exit width of at least 4 feet.2.) Any resident have the potential to be affected.3.) Maintenance Supervisor will monitor throughout facility on his daily rounds to ensure exit width of at least 4 feet and will report to HFA daily.4.) Maintenance Supervisor will report to the Q.A. Committee for 6 months to ensure continued compliance.5.) Date Completed: 11/15/2013</p>	11/15/2013			

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K010046 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 6 of 8 battery powered lights for 12 months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. 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 all residents staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Inside" and "Outside" "Annual Emergency Light Testing" documentation dated 09/06/13 and 10/23/12 during record review with the Maintenance Supervisor from 10:00 a.m. to 12:00 p.m. on 10/17/13, documentation of an annual ninety minute test for six of eight battery operated emergency lights in the facility within the most recent twelve month period was not</p>	K010046	K-0461.) Maintenance Supervisor immediately tested and documented all eight emergency battery powered lights as required. Annual testing of 1 1/2 hour duration and documentation completed and all equipment is fully operational for the duration of the test.2.) Any resident have the potential to be affected.3.) Maintenance Supervisor will continue testing as required and will report to the administrator weekly. Maintenance Supervisor will obtain the HFA signature confirming testing was completed.4.) Maintenance Supervisor shall report to the Q.A. Committee for 6 months and follow any recommendations.5.) Date Completed: 11/15/2013	11/15/2013			

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	<p>available for review. Based on interview at the time of record review, the Maintenance Supervisor stated eight battery operated emergency lights are installed in the facility and acknowledged annual testing documentation for six of the eight battery operated emergency lights was not available for review. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 10/17/13, eight battery operated emergency lights were observed installed in the facility and each light functioned when their respective test button was depressed.</p> <p>3.1-19(b)</p>			

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NAME OF PROVIDER OR SUPPLIER  BROOKSIDE HAVEN HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 N GAVIN ST MUNCIE, IN 47303			
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K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>1. Based on record review and interview, the facility failed to document fire drills conducted on the first and third shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Report of Monthly Fire Drill" documentation with the Maintenance Supervisor during record review from 10:00 a.m. to 12:00 p.m. on 10/17/13, documentation of a fire drill conducted on the first shift and the third shift for the third quarter of 2013 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged documentation of a fire drill conducted on the first shift and the third shift for the third quarter of 2013 was not available for review.</p>	K010050	<p>K-0501.) Facility immediately conducted a fire drill on all three shifts and documented activation of the fire alarm system and transmission of the alarm signal.2.) Any resident have the potential to be affected.3.) Maintenance Supervisor will conduct a fire drill for each shift for each quarter with the appropriate documentation of activation of fire alarm system and transmission of the alarm signal.4.) Maintenance Supervisor will report to the Q.A. Committee along with his "Report of Monthly Fire Drills Report" for 6 months. HFA will monitor to ensure monthly Fire Drill completion with the appropriate documentation.5.) Date Completed: 11/15/2013</p>	11/15/2013			

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	<p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to activate the fire alarm system for fire drills conducted between 6:00 a.m. and 9:00 p.m. on the first shift for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Report of Monthly Fire Drill" documentation with the Maintenance Supervisor during record review from 10:00 a.m. to 12:00 p.m. on 10/17/13, documentation for the first shift fire drill conducted at 2:00 p.m. on 08/29/13 stated "Not sent - simulated" in response to "Confirmed that signal was received by ADT." Based on interview at the time of record review, the Maintenance Supervisor acknowledged 1 of 4 first shift fire drills conducted before 9:00 p.m. did not include activation of the</p>						

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	<p>fire alarm system and transmission of the fire alarm signal.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to document fire drills conducted on the third shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Report of Monthly Fire Drill" documentation with the Maintenance Supervisor during record review from 10:00 a.m. to 12:00 p.m. on 10/17/13, documentation for the third shift fire drill conducted in March 2013 stated "11:00 p.m. to 7:00 a.m." as the time the drill was conducted. No date for the month the fire drill was conducted was documented and the drill stated "Note: Fire drill was conducted. Previous Director of Maintenance failed to complete paperwork." Based on interview at the time of record review, the Maintenance Supervisor acknowledged the March 2013 third shift fire drill documentation did not record the date of the month the fire drill was conducted.</p> <p>3.1-19(b)</p>						

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K010062 SS=E	<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 2 of over 100 sprinklers in the facility which had paint on them or were corroded. 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 30 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 10/17/13, the following was noted:</p> <p>a. the automatic sprinkler in the Janitor Closet which is the maintenance storage area had paint on the sprinkler.</p> <p>b. the automatic sprinkler in the Janitor Closet by Room 8 had turned green with</p>	K010062	<p>K-0621.) Immediately notified our monitoring company for replacement of the two automatic sprinklers. (a) one in Janitor Closet (maintenance storage) with paint on the sprinkler. (b) Janitor Closet (mop room) by room 8 had turned green with corrosion and paint on sprinkler.2.) Any residnet have the potential to be affected.3.) Maintenance Supervisor will monitor daily during regular facility rounds to ensure no paint or corrosion on sprinklers and shall report to HFA weekly.4.) Maintenance Supervisor will report to the Q.A. Committee for 6 months to ensure compliance.5.) Date Completed: 11/15/2013</p>	11/15/2013
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	<p>corrosion and had paint on the sprinkler. Based on interview at the time of observations, the Maintenance Supervisor acknowledged the aforementioned automatic sprinklers each had paint on them with the latter location being corroded.</p> <p>3.1-19(b)</p>			

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K010067 SS=C	<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 and interview, the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance at least once every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 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 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Masiongale Electrical-Mechanical Company "Work Order" documentation dated 12/06/12 during record review with the Maintenance Supervisor from 10:00 a.m.</p>	K010067	K-0671.) Immediately notified Masiongale Electrical-Mechanical Company and requested an itemized listing from their last inspection on 12/06/12 for each fire damper for their location and results.2.) Any resident have the potential to be affected.3.) Maintenance Supervisor shall ensure upon all inspections that an itemized report shall be completed for the facility records to ensure continued compliance. HFA will review all reports and will monitor weekly for compliance.4.) Maintenance Supervisor shall report to the Q.A. Committee for 6 months to ensure compliance.5.) Date Completed: 11/15/2013	11/15/2013			

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	<p>to 12:00 p.m. on 10/17/13, documentation of an itemized listing of each fire damper location and the results of the test for each damper was not available for review. The aforementioned documentation stated "checked all dampers present, all dampers work good when spring is removed." Based on interview at the time of record review, the Maintenance Supervisor stated he was unaware of the total number and location of fire dampers installed in the facility and acknowledged an itemized listing of fire damper locations and the results of testing was not available for review.</p> <p>3.1-19(b)</p>			

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K010072 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are 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 obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure 1 of 3 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 10/17/13, one of four upholstered chairs in the main lobby was placed in the means of egress to the main exit by the nurses station. The corridor exit in the main lobby by the nurses station is marked as a facility exit. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the main lobby exit was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>3.1-19(b)</p>	K010072	<p>K-0721.) We immediately moved upholstered chair in the main lobby to ensure egress by nurses station maintains an exit width of at least 4 feet.2.) Any resident have the potential to be affected.3.) Maintenance Supervisor will monitor throughout facility during his daily rounds to ensure exit width of at least 4 feet. HFA will monitor daily to ensure compliance.4.) Maintenance Supervisor will report to the Q.A. Committee for 6 months to ensure continued compliance.5.) Date Completed: 11/15/2013</p>	11/15/2013			

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K010130 SS=F	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 22 of 22 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Brookside Haven Health Care Center "Smoke Detectors" during record review with the Maintenance Supervisor from 10:00 a.m. to 12:00 p.m. on 10/17/13, the aforementioned policy for resident sleeping room battery operated smoke detectors stated a Monday through Friday daily functional test of each smoke detector shall be recorded, a log will be kept to record battery replacement every six months or as they are needed and a cleaning log will be kept to record weekly smoke detector cleaning. Based on review of "Daily Preventive Maintenance for Brookside Haven Health Care Center" for the twelve month period of October</p>	K010130	<p>K-1301.) Immediately numbered each smoke detector in each resident room with room number, implemented form to ensure functional test, battery replacement at least every 6 months, or as needed, and weekly cleaning log. (See Exhibit "A")2.) Any residnet have the potential to be affected.3.) Maintenance Supervisor will maintain Smoke Detector Log daily to ensure continued compliance. HFA will also monitor daily.4.) Facility maintenance supervisor shall report to the Q.A. Committee for 6 months to ensure on-going compliance.5.) Date Completed: 11/15/2013</p>	11/15/2013			

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	<p>2012 through September 2013, an itemized listing of the results of daily battery operated smoke detector location functional testing was not available for review. In addition, the aforementioned preventive maintenance log did not document battery replacement and smoke detector cleaning. Based on interview at the time of record review, the Maintenance Supervisor stated no additional battery operated smoke detector testing, cleaning or battery replacement documentation was available for review and acknowledged an itemized listing of the results of daily battery operated smoke detector functional testing, battery replacement and cleaning was not available for review. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 10/17/13, battery operated smoke detectors were observed installed in each resident sleeping room.</p> <p>3.1-19(a)</p>			

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K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips was not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 10/17/13, a refrigerator, microwave oven and a coffee pot were each plugged into a power strip in the Diet Kitchen storage room near the nurses station. Based on interview at the time of observation, the Maintenance Supervisor acknowledged a power strip was in use as a substitute for fixed wiring for a refrigerator, microwave oven and a coffee pot at the aforementioned location.</p> <p>3.1-19(b)</p>	K010147	K-01471.) Immediately unplugged the refrigerator, microwave and coffee pot from power strip and plugged into outlets in wall in the diet kitchen.2.) Any resident have the potential to be affected.3.) HFA, Dietary Manager and Maintenance Supervisor will monitor all electrical appliances throughout facility to ensure power strip is not being used. 4.) Maintenance Supervisor will report to the Q.A. Committee for 6 months to ensure compliance.5.) Date Completed: 11/15/2013	11/15/2013			

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