

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155606	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	X3) DATE SURVEY COMPLETED 02/16/2012
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NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/15/12 and 02/16/12</p> <p>Facility Number: 000497 Provider Number: 155606 AIM Number: 100291530</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Westside Retirement Village 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 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was surveyed as Type II (000) construction and fully sprinklered because a one story building addition of Type II (000) construction was approved on 08/24/07 and the major renovation of the original one story building of Type II (222) construction</p>	K0000	Preparation and execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because the provision of federal and state laws require it.	

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>was approved 05/28/08. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. The facility has a capacity of 132 and had a census of 103 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/23/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-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 in approved 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. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 smoke barriers was maintained to provide the one hour fire resistance rating of the smoke barrier. 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 any resident, staff or visitor in the vicinity of the smoke barrier wall near the entrance to the Therapy Gym.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the</p>	K0025	<p>K 025 Smoke Barrier 1. Corrective Actions: All residents, staff or visitors, in the vicinity of the smoke barrier wall near the entrance of the therapy gym are affected by the deficient practice of not maintaining the provision of the one hour fire resistance rating of a smoke barrier. The maintenance Director installed a 7x7inch (5/8 thick Firecheck brand) drywall in the opening in the drywall in the smoke barrier wall above the ceiling by the entrance to the therapy gym on 3/1/2012. 2. Other residents having the potential to be affected by the deficient practice: All residents, staff or visitors, in the vicinity of the smoke barrier wall near the entrance of the therapy gym are affected by the deficient practice of not maintaining the provision of the one hour fire resistance rating of a smoke barrier. 3. Measures/Systematic changes: Vendors or service workers will</p>	03/17/2012	

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	<p>facility from 9:10 a.m. to 12:10 p.m. on 02/16/12, the smoke barrier wall above the ceiling by the entrance to the Therapy Gym had a five inch by five inch hole cut in the drywall which was not firestopped. Based on interview at the time of observation, the Maintenance Director acknowledged there is a five inch by five inch opening in the drywall in the smoke barrier wall above the ceiling by the entrance to the Therapy Gym which was not firestopped.</p> <p>3.1-19(b)</p>		<p>be observed for any opening to a smoke barrier as a result of construction of installation work that was completed. Maintenance Director will inspect all smoke barrier walls and areas monthly to assure compliance.</p> <p>4. Corrective actions monitoring: Executive Director and Maintenance Director will review results of monthly inspections at monthly Safety committee for three consecutive months, then quarterly thereafter.</p> <p>5. Date completed: march 17, 2012</p>	

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 9 doors serving hazardous areas such as the kitchen would latch into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the west entry door to the kitchen from the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 9:10 a.m. to 12:10 p.m. on 02/16/12, the west entry door to the kitchen from the Main Dining Room is equipped with a positive latching device but the latching device failed to latch the door into the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the west entry door to the kitchen from the Main Dining Room failed to latch the door into the door frame.</p> <p>3.1-19(b)</p>	K0029	<p>K 029 Hazardous Areas/ Self Closing Doors #11. Corrective Actions: All residents, staff or visitors, in the vicinity of the west entry door to the kitchen from the Main Dining Room are affected by the deficient practice of a latching device that failed to latch the door into the door frame. The Maintenance Director completed the necessary repairs to the door frame and latching device to ensure that the west entry door to the kitchen from the main Dining Room latches to the door frame. This repair was completed on 3/1/2012.2. Other residents having the potential to be affected by the deficient practice: All residents, staff or visitors, in the vicinity of the west entry door to the kitchen from the Main Dining Room are affected by the deficient practice of a latching device that failed to latch the door into the door frame.3. Measures/Systematic changes: The Maintenance Director will completed weekly door checks for all positive latching devices and enter these findings in TELS monitoring system. 4. Corrective actions monitoring: Executive</p>	03/17/2012			

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	<p>2. Based on observation and interview, the facility failed to enclose 1 of 9 hazardous areas within a one hour rated fire barrier. This deficient practice could affect any resident, staff or visitor in the vicinity of Room 203 in the Alzheimer's Wing.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 9:10 a.m. to 12:10 p.m. on 02/16/12, a mobile soiled linen and laundry cart was unattended and stored in the corridor near Room 203 in the Alzheimer's Wing. The mobile soiled linen and laundry cart consists of two 32 gallon capacity receptacles which contained soiled linen and trash which created a hazardous area. Based on interview at the time of observation, the Maintenance Director acknowledged the mobile cart receptacles left unattended near Room 203 exceeded the capacity of 32 gallons within any 64 square feet area and are not enclosed in a one hour rated fire barrier.</p> <p>3.1-19(b)</p>		<p>Director and Maintenance Director will review the door checks at monthly Safety Meeting for three consecutive months then quarterly thereafter.5. Date completed: March 17, 2012. K 029 Hazardous Areas/ Self Closing Doors #2</p> <p>1. Corrective Actions: All residents, staff or visitors, in the vicinity of Room 203 in the Alzheimer's Wing are affected by the deficient practice when the two 32 gallon capacity soiled linen and trash receptacles were unattended in a 64 square feet area (creating a hazardous area). Maintenance and Housekeeping Directors removed the two 32 gallon containers from the double dollies. Mobil soiled linen receptacles has been replaced with smaller linen carts and 32 gallon trash containers have also been replaced with smaller receptacles to prevent hazardous areas within a 64 square foot area.</p> <p>2. Other residents having the potential to be affected by the deficient practice: All residents, staff or visitors, in the vicinity of Room 203 in the Alzheimer's Wing are affected by the deficient practice when the two 32 gallon capacity soiled linen and trash receptacles were unattended in a 64 square feet area (creating a hazardous area).</p> <p>3. Measures/Systematic changes: Maintenance Director will do environmental rounds/ audits</p>	

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			<p>daily to ensure compliance with soiled linen and trash exceeding the 64 square foot area and creating hazardous environment. Results of audits will be reviewed at monthly Safety meeting for three consecutive months then quarterly thereafter.</p> <p>4. Corrective actions monitoring: Maintenance Director and Executive Director will review the results of the audits at monthly Safety meeting for three consecutive months then quarterly thereafter.</p> <p>5. Date completed: March 17, 2012.</p>	

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K0038 SS=E	<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. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 2 of 9 delayed egress locks was readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided an irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the</p>	K0038	<p>K 038 Exit Access1. Corrective Actions: All residents, staff or visitors can be affected by the deficient practice if needing to exit the facility from Exit #5 and Exit #6 in the 300 Hall when delayed egress locks do not release within 15 seconds upon application of a force. The signage for the two delayed egresses were removed and signage with exit codes were posted immediately. 2. Other residents having the potential to be affected by the deficient practice: All residents, staff or visitors can be affected by the deficient practice if needing to exit the facility from Exit #5 and Exit #6 in the 300 Hall when delayed egress locks do not release within 15 seconds upon application of a force. 3. Measures/Systematic changes: Maintenance Director will do weekly door checks/ audits to ensure door codes operate and provide exits that are readily accessible for all residents, staff and visitors. Door checks/ audits will be entered into TELs tracking system. Results of audits will be reviewed at monthly Safety meeting for three consecutive months then quarterly thereafter. 4. Corrective actions monitoring: Maintenance Director and Executive Director will review the results of the audits at</p>	03/17/2012			

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	<p>authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. This deficient practice could any resident, staff or visitor if needing to exit the facility from Exit # 5 and Exit # 6 in the 300 Hall.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 9:10 a.m. to 12:10 p.m. on 02/16/11, facility Exit # 5 and Exit # 6 in the 300 Hall are each provided with delayed egress locks and were provided with the proper signage indicating the doors can be opened in 15 seconds by pushing on the door, however, when the doors were pushed, the irreversible process to release the lock was not initiated. Based on interview at the time of observation, the Maintenance Director acknowledged Exit # 5 and Exit # 6 in the 300 Hall did not release the lock within 15 seconds after application of a force to the release device and open each exit door.</p> <p>3.1-19(b)</p>		<p>monthly Safety meeting for three consecutive months then quarterly thereafter.5. Date completed: March 17, 2012</p>		

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K0048 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1</p> <p>Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 18.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice affects any resident, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire safety plan titled "Fire Safety and Disaster Preparedness: Departmental Fire Procedures-Dietary" during record review with the Maintenance Director from 9:05 a.m. to 12:10 p.m. on 02/15/12, the fire safety plan did not address the use of</p>	K0048	<p>K 048 Fire Safety Plan1.Corrective Actions All residents, staff or visitors, in the vicinity of the kitchen can be affected by the deficient practice of written fire plan that does not address the use of ABC type and K class fire extinguishers located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The facility has updated the fire safety plan to address the use of ABC type and K class fire extinguishers located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. (See Attachment: Fire Safety Policy)2. Other residents having the potential to be affected by the deficient practice: All residents, staff or visitors, in the vicinity of the kitchen can be affected by the deficient practice of written fire plan that does not address the use of ABC type and K class fire extinguishers located in the kitchen in relationship with the use of the kitchen overhead extinguishing system.3. Measures/Systematic changes: Maintenance and Dietary Directors will in-service Dietary staff with the updated fire safety policy by 3/17/12. Maintenance will hold fire drills monthly and interview Dietary staff during the</p>	03/17/2012
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	<p>ABC type fire extinguishers and the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Maintenance Director acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K class fire extinguisher.</p> <p>3.1-19(b)</p>		<p>drills to assess knowledge of Fire Safety plan that addresses the use of ABC type and K class fire extinguishers located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Results of inservices/ audits will be reviewed at monthly Safety Committee meeting for three consecutive months then quarterly thereafter.4. Corrective actions monitoring: Maintenance Director and Executive Director will review the results of the audits at monthly Safety meeting for three consecutive months then quarterly thereafter.5. Date completed: March 17, 2012</p>	

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K0050 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. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to document fire drills on the second and third shift for 2 of 4 calendar quarters. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "TELS: Fire Drills" documentation with the Maintenance Director during record review from 9:05 a.m. to 12:10 p.m. on 02/15/12, fire drill records were not available for review for the second shift for the second and third quarter of 2011, or for the third shift for the first and second quarter of 2011. Based on interview at the time of record review, the Maintenance Director acknowledged fire drill records for the aforementioned shifts and quarters were not available for review.</p> <p>3.1-19(b)</p>	K0050	<p>K 050 Fire Drills1. Corrective Actions: All residents, staff or visitors are affected by the deficient practice of failure to document fire drills on the second and third shift for 2 of 4 calendar quarters. All fire drills will be documented monthly by Maintenance Director or Designee to ensure staff is familiar with procedures and is aware that drills are part of an established routine.2. Other residents having the potential to be affected by the deficient practice: All residents, staff or visitors are affected by the deficient practice of failure to document fire drills on the second and third shift for 2 of 4 calendar quarters.3. Measures/Systematic changes: All fire drills will be documented monthly by Maintenance Director or Designee and entered in TELS tracking system. Documentation of drills will be reviewed at monthly Safety meeting to ensure staff is familiar with procedures</p>	03/17/2012			

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	3.1-51(c)		and is aware that drills are part of an established routine.4. Corrective actions monitoring: Safety meeting minutes will be reviewed by Executive Director at Monthly at PI meeting to ensure all fire drills are documented and staff is familiar with procedures and is aware that drills are part of an established routine.5. Date completed: March 17, 2012	

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K0064 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6</p> <p>Based on observation and interview, the facility failed to maintain 2 of 2 portable K class fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents, staff or visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the</p>	K0064	<p>K 064 Portable Fire Extinguishers.1. Corrective Actions: All residents, staff or visitors, in the vicinity of the kitchen can be affected by the deficient practice of not having a placard conspicuously placed near a fire extinguisher which states which the fire protection system shall be activated prior to using the fire extinguisher. The Maintenance Director contracted with vendor (SafeCare) on 2/24/12 and both (2 of 2) Class K fire extinguishers now have placards. 2. Other residents having the potential to be affected by the deficient practice: All residents, staff or visitors, in the vicinity of the kitchen can be affected by the deficient practice of not having a placard conspicuously placed near a fire extinguisher which states which the fire protection system shall be activated prior to using the fire extinguisher.3. Measures/Systematic changes: Maintenance will hold fire drills monthly and interview Dietary staff during the drills to assess knowledge of Fire Safety plan that addresses the use of ABC type and K class fire extinguishers and verify placards are still visible and conspicuously placed near a fire extinguisher</p>	03/17/2012			

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	<p>facility from 9:10 a.m. to 12:10 p.m. on 02/16/12, a placard was not conspicuously placed near each of two K class portable fire extinguishers located in the kitchen which states the fire protection system shall be activated prior to using the K class portable fire extinguisher. Based on interview at the time of the observations, the Maintenance Director acknowledged a placard was not conspicuously placed near each of the K class portable fire extinguishers stating the fire protection system shall be activated prior to using the K class portable fire extinguisher.</p> <p>3.1-19(b)</p>		<p>which states which fire protection system shall be activated prior to using the fire extinguisher. Results of inservice/ audits will be reviewed at monthly Safety Committee meeting for three consecutive months then quarterly thereafter.4. Corrective actions monitoring: Maintenance Director and Executive Director will review the results of the audits at monthly Safety meeting for three consecutive months then quarterly thereafter.5. Date completed: March 17, 2012</p>		

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K0067 SS=E	<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. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A</p> <p>Based on record review, observations and interview; the facility failed to provide dampers and service openings for heating and air conditioning system ductwork which penetrates 4 of 15 fire walls in the facility. NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, 1999 Edition, Section 3-3.1.2 states approved fire dampers shall be provided in all air transfer openings in partitions that are required to have a fire resistance rating and in which other openings are required to be protected. Section 2-3.4.1 states a service opening shall be provided in air ducts adjacent to each fire damper, smoke damper, and smoke detector. The opening shall be large enough to permit maintenance and resetting of the device. This deficient practice could affect any residents, staff or visitors in the vicinity of the fire wall near the Therapy Room, Central Supply Room, Housekeeping and the Laundry Room.</p> <p>Findings include: Based on a review of SafeCare "Service</p>	K0067	<p>K 067 Fire Dampers1. Corrective Actions: All residents, staff or visitors, in the vicinity of the fire wall near the Therapy room, Central Supply room, Housekeeping and Laundry room can be affected by the deficient practice of not having fire dampers and service openings for heating and air conditioning system ductwork which penetrates 4 Of 15 fire walls in the facility. Facility has contracted with vendor (SafeCare) for the installation of fire dampers and service openings for the 4 of 15 fire walls in the facility that were identified in the fire damper inspection report dated 2/13/12. Fire damper and service openings will be completed by 3/17/12.2. Other residents having the potential to be affected by the deficient practice: All residents, staff or visitors, in the vicinity of the fire wall near the Therapy room, Central Supply room, Housekeeping and Laundry room can be affected by the deficient practice of not having fire dampers and service openings for heating and air conditioning system ductwork which penetrates 4 Of 15 fire walls in the facility.3. Measures/Systematic</p>	03/17/2012			

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	<p>Call Report" documentation dated 02/13/12 during record review with the Maintenance Director from 9:05 a.m. to 12:10 p.m. on 02/15/12, the facility's fire damper inspections report stated:</p> <p>a) Firewall near the Therapy Room needs two 14 by 26 fire dampers installed and a 16 by 16 access door.</p> <p>b) Central Supply Room needs an 8 inch round fire damper, a 10 inch round fire damper and a 12 inch round access door installed.</p> <p>c) Housekeeping firewall needs a 10 by 20 fire damper and 12 by 12 access door installed.</p> <p>d) Laundry Room needs a 12 by 12 access door installed.</p> <p>Based on observations during a tour of the facility from 9:10 a.m. to 12:10 p.m. on 02/16/12:</p> <p>a) a heating and air conditioning duct above the suspended ceiling was penetrating the two hour fire wall separating the 300 Hall from the corridor by the Therapy Gym with no fire damper or access door observed in the two hour fire rated wall.</p> <p>b) heating and air conditioning ducts above the suspended ceiling in the Central Supply Room, Housekeeping and the Laundry Room were penetrating the one hour smoke barrier walls separating each of these rooms from the corridor.</p> <p>Based on interview at the time of the</p>		<p>changes: Facility will contract with the vendor SafeCare in the required inspections of Fire dampers and service openings for routine maintenance and inspections. Results of these inspections will be reviewed at Safety Committee. By Maintenance Director⁴. Corrective actions monitoring: Maintenance Director and Executive Director will review results of these inspections at Safety Committee.⁵ Date completed: March 17, 2012</p>				

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	<p>observations, the Maintenance Director acknowledged there is no damper or service door in the heating and air conditioning ductwork penetrating the one hour smoke barrier walls separating the corridor from the aforementioned locations.</p> <p>3.1-19(b)</p>			

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K0075 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq. ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9 sq. m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 18.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for mobile soiled linen or trash collection receptacles was not exceeded within any 64 square feet area for 1 of 7 corridors. This deficient practice could affect any resident, staff or visitor in the vicinity of Room 203 in the Alzheimer's Wing.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 9:10 a.m. to 12:10 p.m. on 02/16/12, a mobile soiled linen and laundry cart was unattended and stored in the corridor near Room 203 in the Alzheimer's Wing. The mobile soiled linen and laundry cart consists of two 32 gallon capacity receptacles which contained soiled linen and trash. Based on interview at the time of observation,</p>	K0075	K 075 Soiled Linen / Trash1. Corrective Actions: All residents, staff or visitors, in the vicinity of Room 203 in the Alzheimer's Wing are affected by the deficient practice when the two 32 gallon capacity soiled linen and trash receptacles were unattended in a 64 square feet area (creating a hazardous area). Maintenance and Housekeeping Directors removed the two 32 gallon containers from the double dollies. Mobil soiled linen receptacles has been replaced with smaller linen carts and 32 gallon trash containers have also been replaced with smaller receptacles to prevent hazardous areas within a 64 square foot area.2. Other residents having the potential to be affected by the deficient practice: All residents, staff or visitors, in the vicinity of Room 203 in the Alzheimer's Wing are affected by the deficient practice when the two 32 gallon capacity soiled linen and trash receptacles were unattended in a	03/17/2012			

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	<p>the Maintenance Director acknowledged the mobile cart receptacles left unattended near Room 203 exceeded the capacity of 32 gallons within any 64 square feet area.</p> <p>3.1-19(b)</p>		<p>64 square feet area (creating a hazardous area).3. Measures/Systematic changes: Maintenance Director will do environmental rounds/ audits daily to ensure compliance with soiled linen and trash exceeding the 64 square foot area and creating hazardous environment. Results of audits will be reviewed at monthly Safety meeting for three consecutive months then quarterly thereafter4. Corrective actions monitoring: Maintenance Director and Executive Director will review the results of the audits at monthly PI meeting for three consecutive months then quarterly thereafter.5. Date completed: March 17, 2012</p>		

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K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located elsewhere on the premises where the prime mover is located outside the building. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 9:10 a.m. to 12:10 p.m. on 02/16/12, a remote shut off device was not found for the emergency generator. Based on interview at the time of observation, the Maintenance Director stated the emergency generator is rated at 400 kW, was manufactured in 2007 and acknowledged the emergency generator</p>	K0144	<p>K- 144 Generator- Remote Stop1. Corrective Actions: All residents, staff and visitors are affected by the deficient practice of ensuring 1 of 1 emergency generators was equipped with a remote manual stop. Facility contracted with vendor SafeCare for the installation of emergency stop switch on the outsides of the generator. This work was completed on 2/29/12.2. Other residents having the potential to be affected by the deficient practice: All residents, staff and visitors are affected by the deficient practice of ensuring 1 of 1 emergency generators was equipped with a remote manual stop.3. Measures/Systematic changes: Maintenance Director will inspect the emergency stop switch on the generator during monthly generator load tests. Results of inspection will be reviewed at monthly safety committee meeting for three consecutive months then quarterly thereafter.4. Corrective actions monitoring: Maintenance Director and Executive Director will review the results of the audits at monthly PI meeting for three consecutive months then quarterly thereafter.5. Date completed: March 17, 2012.</p>	03/17/2012

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	was not equipped with a remote shut off device. 3.1-19(b)			