

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155751	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2016
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NAME OF PROVIDER OR SUPPLIER MEADOW LAKES	STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEADOW LAKE DR MOORESVILLE, IN 46158
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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: 02/24/16</p> <p>Facility Number: 004831 Provider Number: 155751 AIM Number: 200809750</p> <p>At this Life Safety Code survey, Meadow Lakes 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 determined to be of Type V (111) 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 smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 137 and had</p>	K 0000	Meadow Lakes requests a desk review of the attached Plan of Correction	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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K 0018 SS=E Bldg. 01	<p>a census of 125 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 03/03/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 2 of over 100 corridor doors did not have an impediment to closing and latching. This deficient practice could affect 20 residents, staff and visitors in 200 Hall.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance during a tour of the facility from 12:30 p.m. to 3:30 p.m. on 02/24/16, the corridor door to the 200</p>	K 0018	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. The facility removed the door wedges that were placed on the floor to</p>	03/14/2016	

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	<p>Hall Director of Nursing (DON) Office and the 200 Hall Activities Office each had a door wedge placed on the floor to prop each door in the fully open position. Based on interview at the time of the observations, the Director of Maintenance acknowledged the aforementioned corridor doors each had an impediment to closing and latching into the door frame.</p> <p>3.1-19(b)</p>		<p>prop each door open. In addition, the facility removed the spring hinges on the corridor door to the 200 Hall Director of Nursing (DON) Office and the 200 Hall Activities Office and replaced them with regular non-spring loaded hinges. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur? The Maintenance Director or designee will conduct audits during routine rounds to ensure all doors close and latch properly, and to make sure no unapproved objects are propping the doors open. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place? To ensure compliance, the Maintenance Director or designee will complete the CQI Life Safety Code audit tool (Attachment #1) for six months with audits being completed once weekly for one month, then monthly for 5 months by the Maintenance Director or designee. The CQI Life Safety Code audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved then an action plan will be developed. Deficiency in this practice will result in disciplinary</p>	

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K 0021 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <p>(a) The required manual fire alarm system and</p> <p>(b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and</p> <p>(c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2</p> <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.</p> <p>Based on observation and interview, the facility failed to ensure doors to 1 of 2 hazardous areas such as kitchens are self closing and kept in the closed position unless held open by an approved releasing device. This deficient practice could affect 20 residents, staff and</p>	K 0021	<p>action up to and or including termination of the responsible employee.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient</p>	03/14/2016

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	<p>visitors in the 100 Hall dining area.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance during a tour of the facility from 12:30 p.m. to 3:30 p.m. on 02/24/16, the north door set to the 100 Hall dining area vestibule containing the kitchen serving window was propped in the fully open position with two chairs. The north door set was not equipped with magnetic releasing devices wired to the building fire alarm system. The kitchen was open to the serving window vestibule because a fire door was not present in the serving window. Based on interview at the time of observation, the Director of Maintenance acknowledged the 100 Hall dining area serving window vestibule was open to the kitchen and the north door set was propped open with chairs.</p> <p>3.1-19(b)</p>		<p>practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. The facility removed the chairs that were placed on the floor to prop each door open. The facility has installed automatic door releases and magnets on the north doors of the serving galley for 100 Hall dining area. This will ensure doors to hazardous areas such as kitchens are self closing and kept in the closed position unless held open by an approved releasing device, which have now been installed. (See Attachment #2) What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur? The Maintenance Director or designee will conduct audits during routine rounds to ensure all doors close and latch properly, and to make sure no unapproved objects are propping the doors open. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place? To ensure compliance, the Maintenance Director or designee will complete the CQI Life Safety Code audit tool (Attachment #1) for six months with audits being completed once weekly for one</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 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 in approved frames. 8.3, 18.3.7.3, 18.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure openings in 1 of 13 smoke barriers were protected to maintain the one hour fire resistance rating of the smoke barrier. This deficient practice could affect 5 staff or visitors in the service hall.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance during a tour of the facility from 12:30 p.m. to 3:30 p.m. on</p>	K 0025	<p>month, then monthly for 5 months by the Maintenance Director or designee. The CQI Life Safety Code audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved then an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. All walls above the ceiling were inspected and no other areas</p>	03/14/2016

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	<p>02/24/16, the one inch annular space surrounding a four inch in diameter pipe which penetrated the smoke barrier wall above the ceiling at the corridor door set from the service hall into the assisted living dining room was not firestopped. In addition, two four inch in diameter holes and one four inch by four inch hole was also noted in the aforementioned smoke barrier wall above the service hall corridor door set. Based on interview at the time of the observations, the Director of Maintenance acknowledged the aforementioned smoke barrier wall openings were not firestopped to maintain the one hour fire resistance rating of the smoke barrier.</p> <p>3.1-19(b)</p>		<p>were found to be affected. The facility has fixed and repaired the one inch annular space surrounding a four inch in diameter pipe which penetrated the smoke barrier wall above the ceiling at the corridor door set from the service hall into the assisted living room. In addition, the two four inch in diameter holes and one four inch by four inch hole was also fixed and repaired. (See Attachment #3)</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur? The Maintenance Director or designee will do an audit of the smoke barrier walls biannually to check for any punctures or holes that need to be fixed. In addition, the Maintenance Director or designee will accompany any contractors that may be working near smoke barrier walls in order to ensure no damage has accidentally been done to the walls. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place? To ensure compliance, the Maintenance Director or designee will complete the CQI Life Safety Code audit tool (Attachment #1) for six months with audits being completed once weekly for one month, then monthly for 5 months</p>	

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K 0029 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1.</p> <p>Based on observation and interview, the facility failed to ensure doors to 1 of 22 hazardous areas such as kitchens are enclosed with a one hour fire rated barrier and are equipped with self-closing doors which latch into the door frame. This deficient practice could affect 20 residents, staff and visitors in the 100 Hall dining area.</p> <p>Findings include: Based on observations with the Director</p>	K 0029	<p>by the Maintenance Director or designee. The CQI Life Safety Code audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved then an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. The facility has removed the dead bolt and replaced alatching and</p>	03/14/2016

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	<p>of Maintenance during a tour of the facility from 12:30 p.m. to 3:30 p.m. on 02/24/16, the following was noted:</p> <p>a. the 100 Hall dining area dietary entrance door was affixed with a deadbolt as the latching mechanism and was not equipped with a self-closing device.</p> <p>b. the north door set to the 100 Hall dining area vestibule containing the kitchen serving window was propped in the fully open position with two chairs. The kitchen was open to the serving window vestibule because a fire door was not present in the serving window. Based on interview at the time of the observations, the Director of Maintenance acknowledged the 100 Hall dining area dietary entry door to the aforementioned hazardous area was not equipped with a positive latching mechanism and was not equipped with a self-closing device to self-close and latch into the door frame. In addition, the Director of Maintenance acknowledged the kitchen was open to the serving window vestibule and the north door set was propped open which did not enclose the serving window vestibule with a one hour fire rated barrier equipped with self-closing doors which latch into the door frame</p> <p>3.1-19(b)</p>		<p>locking door knob on the 100 kitchen entry door. This will ensure the door to hazardous areas such as kitchens shut and latch appropriately. (See Attachment #4) What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur? The Maintenance Director or designee will conduct an audit during routine rounds to ensure all doors close and latch properly, and to make sure no unapproved objects are propping the doors open. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place? To ensure compliance, the Maintenance Director or designee will complete the CQI Life Safety Code audit tool (Attachment #1) for six months with audits being completed once weekly for one month, then monthly for 5 months by the Maintenance Director or designee. The CQI Life Safety Code audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved then an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible</p>	

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K 0048 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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, 19.7.1.1 Based on record review and interview, the facility failed to document a complete written health care occupancy fire safety plan for 1 of 1 plans which incorporated all items listed in NFPA 101, Section 19.7.2.2. (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 This deficient practice affects all residents, staff and visitors in the event of an emergency. Findings include: Based on review of "Disaster Preparedness Plan" documentation with the Director of Maintenance during record review from 9:05 a.m. to 11:45 a.m. on 02/24/16, the written health care</p>			K 0048	<p>employee. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. The facility has created a document to label the fire doors at the end of the 100 Hall, end of the 200 Hall, end of the 600 Hall, and the end of the 300 Hall. In addition the document will label the smoke doors between 100 Hall and 200 Hall, and 200 Hall and 600 Hall Dining Rooms. (See Attachment #5) What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur? The facility has updated the written fire safety plan to identify the location of smoke and fire barrier doors for evacuation purposes and has been placed in the Disaster Preparedness Plan. The</p>		03/14/2016

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K 0050 SS=C Bldg. 01	<p>occupancy fire safety plan for the facility did not identify the location of smoke barrier doors and fire doors in the facility for the evacuation of smoke compartments. The written fire safety plan in "Section E.1. Fire/Explosion Emergency Action Plan" states "Keep all smoke/fire doors closed" and "Continue moving in sequence all persons in the area until all are past the fire doors. Do not go back through fire doors unless necessary." The written fire safety plan did not identify the location of smoke and fire barrier doors for evacuation purposes. Based on interview at the time of record review, the Director of Maintenance acknowledged the location of smoke barrier doors and fire doors are not identified in the written fire safety plan for the facility for evacuation purposes.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine.</p>		<p>Maintenance Director or designee will conduct an audit to ensure Location of Smoke and Fire Barrier Doors is present in the Disaster Preparedness Plan.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place? To ensure compliance, the Maintenance Director or designee will complete the CQI Life Safety Code audit tool (Attachment #1) for six months with audits being completed once weekly for one month, then monthly for 5 months by the Maintenance Director or designee. The CQI Life Safety Code audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved then an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.</p>	

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	<p>Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to 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 "Monthly Fire Drill Report" documentation with the Director of Maintenance during record review from 9:05 a.m. to 11:45 a.m. on 02/24/16, documentation for the third shift fire drill conducted in the first quarter of 2015 on 03/26/15 did not include the time of day the fire drill was conducted. The aforementioned fire drill report stated is was a third shift fire drill but documentation of the time of day the fire drill was conducted was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the fire drill was a third shift fire drill but acknowledged documentation of the time of day the fire drill was conducted was not available for review.</p>	K 0050	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. The facility will ensure to document fire drills conducted on the third shift by having the Director of Maintenance double check that monthly fire drill reports are timed correctly by his/her staff per facility policy. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur? The Maintenance Director or designee will conduct an audit after each fire drill to ensure fire drill reports are timed correctly by his/her staff per facility policy. How the corrective action(s) will be monitored to ensure the deficient practice will not</p>	03/14/2016

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NAME OF PROVIDER OR SUPPLIER MEADOW LAKES	STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEADOW LAKE DR MOORESVILLE, IN 46158
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K 0067 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2</p> <p>Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air</p>	K 0067	<p>recur, ie., what quality assurance program will be put into place? To ensure compliance, the Maintenance Director or designee will complete the CQI Life Safety Code audit tool (Attachment #1) for six months with audits being completed once weekly for one month, then monthly for 5 months by the Maintenance Director or designee. The CQI Life Safety Code audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved then an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient</p>	03/14/2016

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	<p>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 could affect 50 residents, staff and visitors in the vicinity of the 100, 200, 300, 600 Hall and the Reception Area.</p> <p>Findings include:</p> <p>Based on review of Vanguard Alarm Services "Damper Inspection Testing Record" documentation dated 12/11/15 with the Director of Maintenance during record review from 9:05 a.m. to 11:45 a.m. on 02/24/16, 11 of 238 fire dampers were stated as "no access" as the result of four year inspection and maintenance. In addition, the fire damper located in the "Dietary Office" was listed as "Fail" due to being "wired open." Additional fire damper inspection and maintenance in the most recent four year period was not available for review. Based on observations with the Director of</p>		<p>practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. The testing of the twelve (12) dampers was completed on 3/11/2016. (See attachment #6) What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur? All dampers will be tested and documented at least every four years to be in compliance. The Preventative Maintenance Log will be checked monthly by the Maintenance Director or designee to ensure compliance per facility policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place? To ensure compliance, the Maintenance Director or designee will complete the CQI Life Safety Code audit tool (Attachment #1) for six months with audits being completed once weekly for one month, then monthly for 5 months by the Maintenance Director or designee. The CQI Life Safety Code audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved then an action plan will be</p>	

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K 0069 SS=D Bldg. 01	<p>Maintenance during a tour of the facility from 12:30 p.m. to 3:30 p.m. on 02/24/16, fire dampers were noted in ductwork behind cover plates in the 100 Hall (front) furnace room, 100 Hall furnace room (rear) and in the furnace room by Therapy each of which were listed as "no access" on the aforementioned documentation. Based on interview at the time of the observations, the Director of Maintenance stated all fire dampers in the facility are accessible based upon facility fire damper testing on 02/28/11 and acknowledged fire damper inspection and maintenance documentation within the most recent four year period for the aforementioned twelve fire dampers was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 kitchen range hood fire suppression system's nozzles were correctly positioned in relation to moveable cooking equipment. LSC 9.2.3 requires commercial cooking equipment to be in compliance with NFPA 96, 1998 Edition, the Standard for</p>	K 0069	<p>developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and</p>	03/14/2016

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	<p>Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 7-2.2.1 requires automatic fire extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable:</p> <ul style="list-style-type: none"> a. NFPA 12, Standard on Carbon Dioxide Extinguishing Systems b. NFPA 13, Standard for the Installation of Sprinkler Systems c. NFPA 17, Standard for Dry Chemical Extinguishing Systems d. NFPA 17A, Standard for Wet Chemical Extinguishing Systems <p>NFPA 17A, Standard for Wet Chemical Extinguishing Systems, 1998 Edition, 3-6.3 states moveable cooking equipment shall be provided with a means to ensure that it is correctly positioned in relation to the appliance discharge nozzle during cooking operations. This deficient practice could affect two staff in the Assisted Living kitchen adjoining the service hall.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance during a tour of the facility from 12:30 p.m. to 3:30 p.m. on 02/24/16, the Assisted Living kitchen adjoining the service hall had two fire</p>		<p>what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. The facility has installed a new fire suppression system nozzle over the fryer. (See Attachment #2)</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur? The Maintenance Director or designee will audit during routine rounds to ensure the kitchen is in compliance with automatic fire extinguishing systems. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place? To ensure compliance, the Maintenance Director or designee will complete the CQI Life Safety Code audit tool (Attachment #1) for six months with audits being completed once weekly for one month, then monthly for 5 months by the Maintenance Director or designee. The CQI Life Safety Code audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved then an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including</p>	

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	<p>suppression system nozzles positioned over a griddle and a natural gas fired range but had no fire suppression system nozzle positioned over a moveable deep fryer. Based on interview at the time of the observations, the Director of Maintenance acknowledged a kitchen range hood fire suppression system nozzle was not positioned over the moveable deep fryer in the Assisted Living kitchen adjoining the service hall.</p> <p>3.1-19(b)</p>		<p>termination of the responsible employee.</p>		