

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155197	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/22/2014
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NAME OF PROVIDER OR SUPPLIER SANCTUARY AT ST PAULS	STREET ADDRESS, CITY, STATE, ZIP CODE 3602 S IRONWOOD DR SOUTH BEND, IN 46614
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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: 01/22/14</p> <p>Facility Number: 000104 Provider Number: 155197 AIM Number: 100266590</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist, Libby Fruth, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Sanctuary at St. Pauls was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This three story facility with a partial basement was determined to be of Type II (222) construction and was fully sprinklered with the exception of the Health Center elevator machine room.</p>	K010000		

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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K010011 SS=E	<p>The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The resident sleeping rooms are provided with battery operated smoke detectors. The facility has a capacity of 78 and had a census of 73 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered with the exception of the Health Center elevator machine room.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/28/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p>			

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	<p>Based on observation and interview, the facility failed to provide a two hour fire rated separation in 1 of 1 two hour fire rated walls between the Health Center and the assisted living occupancy with firestopped fire barrier penetrations. LSC Section 8.2.3.2.4.2 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 fire barrier shall be filled with a material capable of maintaining the fire resistance of the fire barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 4 residents using facility services on the first floor of the Health Center as well as an undetermined number of staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Healthcare Supervisor from 11:30 a.m. to 12:45 p.m. on 01/22/14, the fire barrier wall above the ceiling tiles at the occupancy separation on the first floor near the kitchen had a one inch unprotected penetration by cables running through a pipe sleeve which was not fire stopped. Based on interview at the time of observation, the Maintenance Healthcare Supervisor</p>	K010011	<p>Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. 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; A2. None, no negative outcomes Q3. What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not recur; A3. Maintenance Director will require all Vendors providing building repair or upgrades to check-in and check-out on a log. Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. Maintenance Director will re-educate maintenance associates on Vendor policy and procedures. Maintenance associate to inspect all work completed by the Vendor meets required safety regulations. Maintenance associate to sign off on the log after inspection completed validating compliance. Maintenance Director to report monthly findings to MDQI Committee for 6 months. Q5. By what date the systemic changes will be completed; A5. February 21, 2014</p>	02/21/2014	

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K010018 SS=E	<p>acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <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 doors protecting corridor openings did not have an impediment to the closing of the doors in 2 of 90 doors. This deficient practice could affect approximately 10 of 73 residents as well as an undetermined number of staff and visitors.</p> <p>Findings include:</p>	K010018	<p>Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. 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; A2. None, no negative outcomes Q3. What measures</p>	02/21/2014	

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	<p>Based on observation with the Maintenance Healthcare Supervisor from 11:30 a.m. to 12:45 p.m. on 01/22/14, the following was noted:</p> <p>a. The second floor nurse's office door was held open by a kick-down door stop attached to the bottom of the door.</p> <p>b. The dietary office door was held open by a kick-down door stop attached to the bottom of the door.</p> <p>Based on interview at the time of observation, the Maintenance Healthcare Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>will be put into place or systematic changes will be made to ensure that the deficient practice does not recur;</p> <p>A3. Maintenance Director has checked all facility doors for improper door stops. Removed kick down door stops and released tension from spring hinged doors. Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. Maintenance Director to educate maintenance associates of proper door opening devices. Maintenance associates to monitor daily for 4 weeks and then continue to monitor weekly on enviromental rounds. Maintenance Director to report monthly findings to MDQI Committee for 6 months. Q5. By what date the systemic changes will be completed; A5. February 21, 2014</p>		

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K010021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</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. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 5 doors serving hazardous areas such as combustible storage rooms over 50 square feet in size were held open only by a device arranged to automatically close the door or close the door upon activation of the fire alarm system. This deficient practice could affect 4 residents using facility services on the 1st floor of the Health Center as well as an undetermined number of staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Healthcare Supervisor from 11:30 a.m. to 12:45 p.m. on 01/22/14, the following was noted:</p>	K010021	<p>Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. 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; A2. None, no negative outcomes Q3. What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not recur; A3. Maintenance Director has disconnected automatic door device on the maintenance shop door and removed plastic wedge from housekeeping/supply room door.Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality</p>	02/21/2014			

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	<p>a. the maintenance shop corridor door was held open by a device, a door closer with a hold open feature that was activated, which would not allow the door to close automatically upon activation of the fire alarm system. This room exceeded 50 square feet. Combustible storage in the maintenance shop included large quantities of cardboard boxes.</p> <p>b. the housekeeping/supply room corridor door was held open by a device, a plastic wedge, which would not allow the door to close automatically upon activation of the fire alarm system. This room exceeded 50 square feet. Combustible storage in the housekeeping/supply room included large quantities of cardboard boxes and paper goods.</p> <p>Based on interview during the times of observation, the Maintenance Healthcare Supervisor acknowledged the doors should not be propped open.</p> <p>3.1-19(b)</p>		<p>assurance program will be put into place; and A4. Educate maintenance and housekeeping associates on appropriate door closure requirements for hazardous areas due to combustible products being stored. Maintenance associate to monitor daily for 4 weeks and continue to monitor on weekly enviromental rounds. Maintenance Director to report monthly findings to MDQI Committee for 6 months. Q5. By what date the systemic changes will be completed; A5. February 21, 2014</p>		

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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 2 of 5 doors serving hazardous areas such as a kitchen closed and latched to prevent the passage of smoke. This deficient practice could affect 4 residents using facility services on the first floor of the Health Center as well as an undetermined number of staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Healthcare Supervisor from 11:30 a.m. to 12:45 p.m. on 01/22/14, the kitchen double set of doors into the dining room were provided with door closers but lacked automatic positive latching hardware on the doors. One of the doors was provided with manual slide bolts at the top and bottom</p>	K010029	<p>Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. 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; A2. None, no negative outcomes Q3. What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not recur; A3. Maintenance Director contracted vendor to install hardware to meet safety regulations. Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. Routine preventative maintenance to be completed. Q5. By what date the</p>	02/21/2014			

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K010034 SS=E	<p>of the door and the other door latched into the other. Based on interview during the time of observation, the Maintenance Healthcare Supervisor acknowledged the aforementioned hazardous area set of doors lacked automatic positive latching hardware to ensure the doors closed and latched into the door frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 9 stairway enclosure doors were in accordance with 7.2. LSC Section 7.2.1.5.4 requires a latch or other fastening device to be provided. This deficient practice affects at least 10 residents on the third floor as well as an undetermined number of staff and visitors on the first floor.</p>			K010034	<p>systemic changes will be completed; A5. February 21, 2014</p> <p>Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. 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; A2. None, no negative outcomes Q3. What measures will be put into place or</p>		02/21/2014

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Healthcare Supervisor from 11:30 a.m. to 12:45 p.m. on 01/22/14, the following was noted:</p> <p>a. The latch on the third floor west stairwell exit door was not functioning and this door was provided with an electromagnetic device that held the door closed when energized. It was acknowledged by the Maintenance Healthcare Supervisor that when the facility loses power or the fire alarm activated, the magnet would release and the stairwell door would not be latched.</p> <p>b. The first floor west stairwell was unlatched with staff going through the door. Based on interview at the time of observation, the Maintenance Healthcare Supervisor indicated the panic bar was "dogged down" (unlocked) and did not know how long the panic bar on the door had been unlocked.</p> <p>3.1-19(b)</p>		<p>systematic changes will be made to ensure that the deficient practice does not recur;</p> <p>A3. Maintenance Director has checked and fixed all doors to ensure proper latching is in place to meet safety requirements.</p> <p>Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. The facility auditing tool for enviromental rounds has been modified to include door latching to be checked twice weekly by maintenance associate. Maintenance Director to report monthly findings to MDQI Committee for 6 months. Q5. By what date the systemic changes will be completed; A5. February 21, 2014</p>				

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building for 1 of 2 elevator machine rooms. NFPA 13, Section 5-1.1 states sprinklers shall be installed throughout the premises. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator</p>	K010056	<p>Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. 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; A2. None, no negative outcomes Q3. What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not recur; A3. Administrator is requesting an extension for noncompliance due to the time frame required to complete installation of the Clean Agent System. Consultation obtained with quotes in process and work to be completed by April 3, 2014. Q4. How the corrective</p>	04/03/2014

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K010062 SS=D	<p>machine room. This deficient practice could affect at least 4 residents, staff and/or visitors in the Health Center.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Healthcare Supervisor from 11:30 a.m. to 12:45 p.m. on 01/22/14, the Health Center elevator machine room lacked sprinkler protection. Based on interview at the time of observation, the Maintenance Healthcare Supervisor acknowledged the lack of sprinkler protection in the Health Center building elevator machine room.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to maintain 14 of 16 sprinklers in the kitchen which had signs of corrosion. 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</p>	K010062	<p>action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. Routine preventative maintenance program as defined by manufacturer. Q5. By what date the systemic changes will be completed; A5. An extension is requested for compliance date of April 3, 2014.</p> <p>Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. 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; A2. None, no negative</p>	02/21/2014			

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K010069 SS=D	<p>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 would not directly affect residents but could affect staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Healthcare Supervisor from 11:30 a.m. to 12:45 p.m. on 01/22/14, fourteen of sixteen sprinkler heads in the kitchen were covered with greenish corrosion and an accumulation of grease and/or dust. Based on interview at the time of the observations, the Maintenance Healthcare Supervisor acknowledged the sprinklers in the kitchen had greenish corrosion with an accumulation of grease and/or dust.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the</p>	K010069	<p>outcomes Q3. What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not recur;</p> <p>A3. Maintenance Director contracted Fire Kingdom to replace all 16 sprinkler heads in the kitchen. Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and</p> <p>A4. Maintenance Director to educate maintenance associates on appropriate condition of sprinkler heads. The facility auditing tool for environmental rounds has been developed to include kitchen sprinkler heads condition inspection on weekly rounds by maintenance associate. Maintenance Director to report monthly findings to MDQI Committee for 6 months. Q5. By what date the systemic changes will be completed; A5. February 21, 2014</p> <p>Q1. What corrective action(s) will</p>	02/21/2014	

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	<p>facility failed to ensure the 1 of 12 grease baffle filters in the kitchen stove hood was properly positioned to drain the grease into the containers. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1998 Edition, at 3.2.7 says grease filters requiring a specific orientation to drain grease shall be clearly so designated, or the hood shall be constructed so filters cannot be installed in the wrong orientation. This deficient practice would not directly affect residents but could affect staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Healthcare Supervisor from 11:30 a.m. to 12:45 p.m. on 01/22/14, one of the grease filter baffles in the kitchen stove hoods was installed horizontally instead of vertically to drain grease from the exhaust hood. Based on interview at the time of observation, the Maintenance Healthcare Supervisor acknowledged the baffle grease filter was not installed vertically.</p> <p>3.1-19(b)</p>		<p>be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. 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; A2. None, no negative outcomes Q3. What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not recur; A3. Maintenance Director contracted Kingdom Fire who replaced all kitchen hood exhaust filters properly inserting as per manufacturer's recommendation. Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. Maintenance Director to educate maintenance associates on proper placement of the grease filters in the kitchen exhaust hoods. The facility auditing tool for environmental rounds has been developed to include inspection of kitchen exhaust hood filters for proper position by maintenance associate. Maintenance Director to report monthly findings to MDQI Committee for 6 months. Q5. By what date the systemic changes will be completed; A5. February 21,</p>		

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K010070 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation, record review, and interview; the facility failed to enforce the policy for the use of 3 of 3 portable space heaters in the facility in accordance with NFPA 101, Section 19.7.8. This deficient practice could affect 4 residents using facility services on the first floor of the Health Center as well as an undetermined number of staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Healthcare Supervisor from 11:30 a.m. to 12:45 p.m. on 01/22/14, a space heater was located in the Admissions office, in the Administrators office and in the Director of Nursing office, nonresident areas, but they were not in use. Based on review of the space heater policy with the Executive Director at the exit conference at 1:15 p.m. on 01/22/14, the facility does allow space heaters in nonsleeping staff and employee areas if the heating element does not exceed 212 degrees</p>	K010070	<p>2014</p> <p>Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. 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; A2. None, no negative outcomes Q3. What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not recur; A3. Maintenance Director immediately developed space heater policy for nonsleeping/employee areas. Maintenance associate immediately tested all 3 heating elements and documented degrees Fahrenheit which did not exceed the NFPA regulation of 212 degrees. Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. Maintenance Director educated maintenance</p>	02/21/2014			

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K010130 SS=B	<p>Fahrenheit. Based on interview at the time of record review, the facility did not have documentation to show the three space heaters' heating elements will not exceed 212 degrees Fahrenheit.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 40 of 40 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 73 residents, staff and visitors on the second and third floor.</p> <p>Findings include:</p> <p>Based on review of documentation with the Maintenance Healthcare Supervisor, on 01/22/14 from 8:30 a.m. to 11:00 a.m., the facility had a document titled, "Health Care Room Smoke Detectors,</p>	K010130	<p>associates on space heater policy. Developed a log to monitor space heater distribution with location, manufacturer brand and tempature recording performed by the maintenance associate. Annual space heater inspection of equipment and tempature test to be performed by October 31st by maintenance associate. Q5. By what date the systemic changes will be completed; A5. February 21, 2014</p> <p>Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. 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; A2. None, no negative outcomes Q3. What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not recur; A3. Maintenance Director and associates conducted smoke detector cleaning and battery functioning test in all 40 resident room. Required documentation recorded on monitoring tool. Q4. How the corrective action(s) will be monitored to ensure the deficient practice will</p>	02/21/2014			

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	Battery Powered Only, Maintenance Program, Battery testing: Weekly, Change Batteries: Annually, Cleaning: Annually (per attached manufacturer's instructions) but there was no actual documentation to demonstrate the batteries were tested, batteries changed or smoke detectors cleaned during the past year. Based on interview at the time of review, the Maintenance Healthcare Supervisor said the health care room smoke detector program had been done during the past year, but not documented. 3.1-19(a)		not recur i.e., what quality assurance program will be put into place; and A4. Maintenance Director to educate the maintenance associates on previous document developed to ensure understanding of proper maintenance required on the smoke detectors in all resident rooms. Maintenance associate to perform weekly smoke detector battery functioning test and yearly cleaning in all resident rooms per manufacturer's recommendation. Maintenance Director to report monthly findings to MDQI Committee for 6 months. Q5. By what date the systemic changes will be completed; A5. February 21, 2014		

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K010143 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas was provided with signage indicating that transferring is occurring. This deficient practice could affect at least 10 residents in the vicinity of the second floor oxygen storage room as well as an undetermined number of staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Healthcare Supervisor from 11:30 a.m. to 12:45 p.m. on 01/22/14, the second floor oxygen storage room was not provided with a sign indicating transferring of oxygen was occurring. Based on interview at</p>	K010143	<p>Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. 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; A2. None, no negative outcomes Q3. What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not recur; A3. Administrator immediately re-created and posted signage indicating "Transfer of Oxygen in Process". Supply Coordinator ordered signage plaque to be permanently mounted to Oxygen Storage Room. Q4. How</p>	02/21/2014			

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K010144 SS=C	<p>1:10 p.m., the Healthcare Administrator acknowledged the oxygen room door was not provided with a sign that indicated transferring of oxygen was occurring.</p> <p>3.1-19(b)</p> <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. Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 12 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This</p>	K010144	<p>the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. Supply Coordinator or designee to monitor Oxygen Storage room daily to ensure signage posted and document on log developed until permanent plaque mounted on door. Q5. By what date the systemic changes will be completed; A5. February 21, 2014</p> <p>Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. 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; A2. None, no negative outcomes Q3. What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not recur; A3. Maintenance Director and electrical contractor H&G tested the generator to ensure sufficient capacity load pick up within 10 seconds. Q4. How the corrective</p>	02/21/2014	

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K010147 SS=E	<p>deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator - Monthly Test Log" documentation with the Maintenance Healthcare Supervisor during record review from 8:30 a.m. to 11:00 a.m. on 01/22/14, documentation of generator load transfer time for the twelve month period of January 2013 through December 2013 was not available for review. Based on interview at the time of record review, the Maintenance Healthcare Supervisor indicated no additional generator transfer time documentation for generator load transfer time was available for review and acknowledged generator load transfer time was not documented for the twelve month period of January 2013 through December 2013.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the</p>	K010147	<p>action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and</p> <p>A4. Maintenance associate to test and document the load transfer time on monthly Emergency Generator Test Log. Maintenance Director to report monthly findings to MDQI Committee for 6 months. Q5. By what date the systemic changes will be completed; A5. February 21, 2014</p> <p>Q1. What corrective action(s) will be accomplished for those</p>	02/21/2014	

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	<p>facility failed to ensure 2 of 2 power strips were 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 4 residents using facility services on the first floor of the Health Center as well as an undetermined number of staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Healthcare Supervisor from 11:30 a.m. to 12:45 p.m. on 01/22/14, in the Physical Therapy Office, a microwave oven was plugged into a power strip and a coffee maker and a refrigerator were plugged into a separate power strip. Based on interview at the time of observation, the Maintenance Healthcare Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. 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; A2. None, no negative outcomes Q3. What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not recur; A3. Maintenance Director has checked the facility for use of power strips and removed if using improperly. Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. Maintenance Director to educate maintenance associates of power strip safety regulation and restrictions. The facility auditing tool for environmental rounds has been modified to include monitoring for power strip usage weekly by maintenance associate. Maintenance Director to report monthly findings to MDQI Committee for 6 months. Q5. By what date the systemic changes will be completed; A5. February 21, 2014</p>		