STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE VALPARAISO	3301 N CALUMET AVE VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	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). Survey Date: 06/16/15 Facility Number: 000176 Provider Number: 155277 AIM Number: 100288940 At this Life Safety Code survey, Aperion Care Valparaiso 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. This facility is located in two, two story buildings with walk out lower levels and connected by the "tunnel", a one story corridor. The two buildings, identified as the Pines and the Manor were determined to be of Type II (111) construction, built prior to March 1, 2003 and fully sprinklered. The facility has a fire alarm system with smoke detection in the	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in resident sleeping Rooms #1 through #37 on the Pines upper level and hard wired smoke detectors supervised by the fire alarm system in rooms 38 through 43 on the Pines lower level. Smoke detectors in resident sleeping rooms on the upper and lower level are hard wired. The facility has the capacity for 150 and had a census of 91 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.			
K 0014 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 Based on observation and interview, the facility failed to provide documentation for the flame spread rating of interior finish materials installed within exit access for 1 of 1 main entrance reception/corridor areas and 1 of 1 Pine lower level corridors and 1 of 1 Maple nurses' station. This deficient practice	K 0014	**K014** **The facility requests paper compliance for this citation.**	07/16/2015

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	could affect all occupants near the main entrance and the Maple nurses' station. The Pine Rehabilitation hall was closed. Findings include: Based on observations on 06/16/15 at 9:50 a.m., wooden boards were installed on the lower one third of the corridor walls in the main entrance and the Pine lower level corridor walls. Based on observation on 06/16/15 at 3:10 p.m., vinyl siding was installed on the wall at the Maple nurses' station. Based on an interview with of Maintenance at the time of observation, documentation was not available to demonstrate the wooden boards and the vinyl siding provide a flame spread rating of Class A or Class B. 3.1-19(b)		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** **Pines lower level wooden boards on lower one third of walls in corridor documentation for verification for flame spread rating requested.** **Main entrance wooden boards on the lower one third of the walls documentation for verification for flame spread rating requested.** **Maple Nurses Station vinyl siding on the walls has been removed and the walls have been painted.**	

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			2) How the facility identified other residents: **Audit for presence of documentation for building materials used for interior finish in corridors and exit ways completed.** **3) Measures put into place/ System changes:** **Documentation for verification of flame spread ratings for building materials used in the facility for interior finish for corridors and exit ways will be obtained and be kept on file. Audit for presence of documentation for verification of flame spread will be done at the time of any new changes in interior finish for corridors and exit ways and will be kept on file. Administrator will be responsible for the oversight.** **4) How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.**	

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			5) Date of compliance: **7/16/2015**	
K 0015 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2 Based on observation and interview, the facility failed to ensure the interior finish for 1 of 1 staff conference has a flame spread rating of Class A, Class B or Class C finish. This deficient practice was not in a resident care area but could affect facility staff. Findings include: Based on observations on 06/16/15 at 12:55 p.m., wooden boards were installed on the lower one third of the conference room walls. Based on an interview with	K 0015	**K015** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this*	07/16/2015

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	of Maintenance at 12:55 p.m., documentation was not available to demonstrate the wooden boards provide a flame spread rating of Class A, Class B or Class C. 3.1-19(b)		*plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** **Conference room walls wooden boards on lower one third of wall: documentation for verification of flame spread rating has been requested.** **2) How the facility identified other residents:** **Audit for presence of documentation for building materials used for interior finish in staff areas completed.**	

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			3) Measures put into place/ System changes: **Documentation for verification of flame spread ratings for building materials used in the facility for interior finish for corridors and exit ways will be obtained and be kept on file. Audit for presence of documentation for verification of flame spread will be done at the time of any new changes in interior finish for corridors and exit ways and will be kept on file. Administrator will be responsible for the oversight.**	
			4) How the corrective actions will be monitored: **The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.**	

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			5) Date of compliance: **716/2015**	
K 0020 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. Based on observation and interview, the facility failed to ensure 1 of 3 ground floor stairway doors in the Pine building would self close and latched into the door frame. LSC 19.3.1.1 requires any vertical opening to be enclosed or protected in accordance with LSC 8.2.5. LSC 8.2.5.2 states the vertical opening shall be enclosed as appropriate for the fire resistance rating of the barrier. LSC 8.2.3.3.1 requires a one hour rated door in a one hour vertical opening. NFPA 80, 2-1.4 requires fire doors to be closed and latched at the time of fire. This deficient practice could affect any of the residents evacuated through the center stairway and gathered in the main entrance lobby of the Pine building. Findings include: Based on an observation and interview on	K 0020	**K020** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	07/16/2015

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	06/16/15 at 9:45 a.m., the Director of Maintenance confirmed the stairway door in the main entrance lobby of the Pine building failed to latch into the door frame. 3.1-19(b)		**1) Immediate actions taken for those residents identified:** **Identified ground floor stairway door has been repaired and is properly latching into the door frame.** **2) How the facility identified other residents:** **All ground floor stairway doors in the facility have been checked to ensure that they are properly latching into the door frames.** **3) Measures put into place/ System changes:** **Audit of ground floor stairway doors will be done during environmental rounds weekly to ensure that they are latching properly into the door frame. Any identified issues during rounds will be corrected. Administrator will be responsible for the oversight.**	

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			4) How the corrective actions will be monitored: **The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.** **5) Date of compliance:** **7/16/2015**	
K 0038 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 4 of 10 exit doors, 1 of 1 set of doors entering Rehabilitation hall and 1 of 5 ground floor stairway doors were accessible.	K 0038	**K038** **The facility requests paper**	07/16/2015

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	Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS " This deficient practice could affect any number of occupants. Findings include: Based on observations with the Director of Maintenance and the Maintenance Assistant on 06/16/15 from 1:20 p.m. to 2:38 p.m., the Pine north exit door on the south end, Pine north exit door on the north end, Manor lower level exit door near the beauty shop, the double doors entering Rehabilitation hall and the Pine south exit stairway door were equipped with electromagnetic locks that released after 15 seconds once the process was engaged. Based on an interview with the Director of Maintenance at the time of observation, he acknowledged the aforementioned doors lacked delayed egress signage.		**compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** **Permanent signs have been ordered for the affected doors. Temporary signs have been posted on the affected doors.** **2) How the facility identified other residents:** **Audit of all doors with**	

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	3.1-15(b)		**electromagnetic locks that release after 15 seconds completed.** **3) Measures put into place/ System changes:** **During weekly environmental rounds doors with electromagnetic locks that release after 15 seconds will be checked to ensure that appropriate signs are in place. Any identified as missing signage will be corrected immediately. Administrator will be responsible for the oversight.** **4) How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.**	

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			5) Date of compliance: **7/16/2015**	
K 0045 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 Based on observation and interview, the facility failed to provide exterior emergency lighting for 10 of 10 emergency exits. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all occupants. Findings include: Based on observation with the Director of Maintenance and the Maintenance Assistant on 06/16/15 during the tour from 12:55 p.m. to 4:00 p.m., exterior lighting fixtures were mounted on the building at every emergency exit. Based on an interview with the Director of Maintenance at the time of observations, he was unable to confirm each light fixture would receive power from the	K 0045	**K 045** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state*	07/16/2015

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	emergency generator in the event of a power outage. 3.1-19(b)		*law.* **1) Immediate actions taken for those residents identified:** **Exterior lighting at emergency exits tested to ensure that they receive power from the emergency generator in the event of a power outage.** **2) How the facility identified other residents:** **Exterior lighting for all emergency exits checked to ensure that they all receive power from the emergency generator.** **3) Measures put into place/ System changes:** **Exterior lighting for all emergency exits will be checked monthly during the emergency generator load testing. Any identified issues will be corrected immediately. Administrator will be responsible**	

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			for the oversight. Maintenance staff in-serviced. **4) How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.** **5) Date of compliance:** **7/16/2015**	
K 0050 SS=F Bldg. 01	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			

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	planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2			
	Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters and fire drills for 4 of the last 4 quarters included the verification of transmission of the fire alarm signal to the monitoring station and fire simulation. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on interview and record review of the "Fire Drill Reports" on 06/16/15 at 10:15 a.m., the Director of Maintenance and the Maintenance Assistant confirmed a fire drill was not conducted on the second shift for the fourth quarter of 2014. Additionally, the documentation for all fire drills performed for the past twelve months lacked verification of the transmission of the signal and simulation of emergency fire conditions. Based on	K 0050	**K 050** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** **Fire Drills have been conducted on all shifts. Verification of transmission of the fire alarm**	07/16/2015

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	interview at the time of record review, the Director of Maintenance acknowledged the transmission of the fire alarm signal to the monitoring station was not documented as well as the simulation of emergency fire conditions for the aforementioned fire drills. 3.1-19(b) 3.1-51(c)		**signal to the monitoring station obtained verbally from the company, written verification has been requested.** **2) How the facility identified other residents:** **Fire Drills completed for each shift and monitoring company contacted to verify transmission.** **3) Measures put into place/ System changes:** **Fire Drills will be conducted for each shift quarterly and request of transmission verification will be obtained with each drill. Documentation of each fire drill and transmission verification will be kept on file. Any identified concerns will be addressed immediately. Administrator to sign off on all fire drills.**	

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			4) How the corrective actions will be monitored: **The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.** **5) Date of compliance:** **7/16/2015**	
K 0062 SS=D Bldg. 01	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 Based on observation and interview, the facility failed to replace the loaded sprinkler head in 1 of 1 main kitchen walk in refrigerators. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.	K 0062	**K 062** **The facility requests paper compliance for this citation.** *This Plan of Correction is the*	07/16/2015

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	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 was not in a resident care area but could affect facility staff. Findings include: Based on observation on 06/16/15 at 2:05 p.m., the Director of Maintenance agreed the sprinkler head in the main kitchen walk in refrigerator was corroded and needed replaced. 3.1-19(b)		*center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** **Valley Fire has been contacted to have sprinkler head in the kitchen walk in refrigerator replaced. Replacement scheduled for 7/7/2015.** **2) How the facility identified other residents:** **Audit of sprinkler heads has**	

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			been completed. No other issues identified.	
			3) Measures put into place/ System changes: **During weekly environmental rounds sprinkler heads will be observed to identify any sprinkler heads that need to be replaced. Any identified concerns will be scheduled for repair. Administrator will be responsible for the oversight.**	
			4) How the corrective actions will be monitored:	

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			The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance:** **7/16/2015**	
K 0066 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4			

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	Based on observation and interview, the facility failed to enforce 1 of 1 smoking policies for the facility. This deficient practice could affect occupants evacuated through the stairway exit from Rehabilitation south hall. Findings include: Based on an observation with the Director of Maintenance on 06/16/15 at 2:50 p.m., two staff members were smoking cigarettes outside the stairway exit door from Rehabilitation south hall. Based on an interview with the Director of Maintenance at the time of observation, he confirmed the exit door was not a designated smoking area and fifteen cigarette butts were counted on the ground near the aforementioned exit door. 3.1-19(b)	K 0066	**K 066** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** **No Smoking signs placed at identified entrance.**	07/16/2015

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			2) How the facility identified other residents: **Audit of entrances completed to identify any other evidence of smoking in non-smoking areas.**	
			3) Measures put into place/ System changes: **During weekly environmental rounds entrance ways will be checked to ensure compliance with policy. Any areas of concern identified will be addressed as indicated. No Smoking signs will be placed by entrance ways. Staff in-serviced on Smoking Policy.**	

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			4) How the corrective actions will be monitored: **The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.** **5) Date of compliance:** **7/16/2015**	
K 0130 SS=E Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview, the facility failed to ensure 5 of 5 Manor building water heaters/boilers had a current inspection certificate to ensure the water heater was in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of residents. This deficient practice could affect residents near the Manor building boiler room.	K 0130	**K 130** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	07/16/2015

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	Findings include: Based on record review and interview on 06/16/15 at 2:00 p.m., the Director of Maintenance acknowledged he was unable to locate and provide Certificate of Inspection for each of the three water heaters and two boilers in the Manor building water heater/boiler rooms. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a battery testing and replacement program was provided to ensure 28 of 28 single station smoke alarms would operate. This deficient practice could affect at least 28 residents. Findings include: Based on record review and interview on 06/16/15 at 10:30 a.m., the Director of Maintenance and the Maintenance Assistant acknowledged they were unable to provide documentation of a battery testing and battery replacement program for the 28 single station smoke alarms installed in resident rooms prior to 2015. 3.1-19(b)		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** **Copies of Certificate of Inspection for the water heaters and boilers in the Manor building have been requested.** **The 28 single station smoke detectors have had battery testing done.** **2) How the facility identified other residents:** **Audit completed for water heaters and boilers throughout the facility to ensure that Certificate of Inspection present.**	

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			All single station smoke detectors have had battery testing done. **3) Measures put into place/ System changes:** **Audits will done quarterly to ensure that Certificates of Inspection are present and current. Any identified concerns will be addressed immediately.** **All single station smoke detectors will have battery testing done monthly. Any identified concerns will be addressed immediately.** **4) How the corrective actions will be monitored:** **The results of these audits will be**	

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			reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance:** **7/16/2015**	
K 0144 SS=F Bldg. 01	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. 1. Based on record review and interview, the facility failed to ensure the annual load bank for 1 of 2 emergency generators was performed correctly. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2.2. Chapter 6-4.2.2 of NFPA 110 requires the supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. This deficient practice could affect all	K 0144	**K 144** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in*	07/16/2015

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	occupants. Findings include: Based on record review and interview with the Director of Maintenance and the Maintenance Assistant on 06/16/15 at 1:04 p.m., both acknowledged but neither could explain why the diesel generator was operated at 81.3 percent load from 10:30 a.m. to 10:50 a.m., zero percent load from 10:50 a.m. to 11:10 a.m., 81.3 percent load from 11:10 a.m. to 11:30 a.m., and 56.4 percent load from 11:30 a.m. to 12:45 p.m.. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 6 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30		*the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** **Load bank completed properly for the diesel emergency generator.** **Monthly generator load testing is in place. Previous year's records are being searched for.** **Emergency lighting checked to ensure that they are working within 10 seconds after loss of normal power.** **2) How the facility identified other residents:** **Load bank completed for other emergency generator.** **3) Measures put into place/ System**	

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	minutes. 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 for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review of the generator log titled "Generating System Exercise Test Run Log" on 06/16/15 at 11:10 a.m., the Director of Maintenance and the Maintenance Assistant acknowledged they were unable to provide documentation of a generator load test prior to 2015. 3.1-19(b) 3. Based on record review and interview, the facility failed to provide the complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. NFPA 99, Section 3-4.1.1.8 states the generator set 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. This deficient practice affects all		**changes:** **Audit will be done monthly to ensure that the load bank for both emergency generators has been properly conducted and that the proper documentation has been completed. Audit will include verifying that the transfer time is documented. Administrator will be responsible for the oversight. Maintenance staff inserviced.** **4) How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.** **5) Date of compliance:**	

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	occupants. Findings include: Based on review of the generator log titled "Generating System Exercise Test Run Log" with the Director of Maintenance and the Maintenance Assistant on 06/16/15 at 10:40 p.m., the emergency generator was tested monthly under load for at least 30 minutes, however, the monthly load test record for the previous year did not include the time for the transfer of power from the main source to the generator. This was acknowledged by the Director of Maintenance. 3.1-19(b)		**7/16/2015**	
K 0147 SS=D Bldg. 01	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 facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring to provide power for medical equipment. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed	K 0147	**K 147** **The facility requests paper compliance for this citation.** *This Plan of Correction is the*	07/16/2015

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	wiring of a structure. This deficient practice could affect 1 resident in resident room 19. Findings include: Based on observation and interview on 06/16/15 at 1:25 p.m., the Director of Maintenance confirmed an oxygen concentrator was supplied with electricity by extension cord power strips in resident room 19. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 receptacles in the Pine south soiled linen room was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subjected to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This		*center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** **Extension cord power strip removed from room 19 and oxygen concentrator plugged into electrical outlet. Room 19 is currently empty.** **Ground fault circuit interrupter in the Pines South soiled linen room has been replaced.** **2) How the facility identified other residents:** **Environmental rounds made to**	

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	deficient practice could affect any facility staff. Findings include: Based on an observation and interview on 06/16/15 at 1:15 p.m., the Director of Maintenance and the Maintenance Assistant confirm the electrical receptacle on the wall within two feet of a sink in the Pine south soiled linen room lacked GFCI protection against electric shock. 3.1-19(b)		**identify use of extension cord power strips in the facility.** **Environmental rounds made to identify all ground fault circuit interrupters are in place and properly functioning.** **3) Measures put into place/ System changes:** **Weekly environmental rounds will be conducted to ensure that extension cord power strips are not being used.** **Weekly environmental rounds will be done to ensure that all needed ground fault circuit interrupters are in place and functioning. Any discrepancies will be corrected immediately. Staff in-serviced on the use of extension cord power strips.** **4) How the corrective actions will be monitored:**	

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