

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155115	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2016
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NAME OF PROVIDER OR SUPPLIER  CARDINAL NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617
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(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	<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: 01/26/16</p> <p>Facility Number: 000048 Provider Number: 155115 AIM Number: 100275330</p> <p>At this Life Safety Code survey, Cardinal Nursing and Rehabilitation Center 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 basement was determined to be of Type II (111) construction with a one story addition determined to be of Type V (111) construction and both were fully sprinklered except for the housekeeping closet in the kitchen. The facility has a fire alarm system with smoke detection</p>	K 0000	<p>The creation and submission of this plan of correction doesnot constitute an admission by this provider of any conclusion set forth in thestatement of deficiencies, or of any violation of regulation.</p> <p>Due to the relative low scope and severity of this survey,the facility respectfully requests a desk review in lieu of a post surveyrevisit on or after 25 February, 2016.</p>	

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 0020 SS=E Bldg. 01	<p>on all levels in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 144 and had a census of 116 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were spinklered except for the housekeeping closet in the kitchen and one detached storage shed.</p> <p>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.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 vertical openings were enclosed with construction having at least a one hour fire resistance. LSC 19.3.1.1 requires any vertical opening to be enclosed or protected in accordance with LSC 8.2.5. LSC 8.2.5.4 refers to 7.1.3.2.1 for enclosure of exits. LSC 7.1.3.2.1 requires openings in the separation be protected by fire door assemblies equipped with door closers complying with 7.2.1.8. NFPA 80, the Standard for Fire Doors and Fire Windows at 2-1.2 requires fire door</p>	K 0020	<p>It is the policy of this facility that 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 in accordance with LSC 19.3.1.1.</p> <p>What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: The third floor North stairway door has been adjusted and now closes automatically and latches into the frame.</p>	02/25/2016

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K 0025 SS=E Bldg. 01	<p>assemblies to include latches. NFPA 80, 2-1.4 requires fire doors to be closed and latched at the time of fire. This deficient practice could affect staff and at least 20 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Executive Director on 01/26/16 at 12:06 p.m., the north third floor stairway door failed to latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director and the Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at</p>		<p>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:</p> <p>The deficient practice had the potential to affect staff and 20 residents. The Maintenance Director or designee inspected every vertical opening to ensure that they latch into their frame.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The third floor North stairway door has been adjusted and now closes automatically and latches into the frame. The Maintenance Director or designee will inspect every vertical opening daily for 7 days, weekly for 4 weeks and monthly for 6 months. 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:</p> <p>The Maintenance Director or designee will inspect every vertical opening daily for 7 days, weekly for 4 weeks and monthly for 6 months. These inspections will be added to the Preventative Maintenance program and will be recorded on the daily/weekly/monthly PM forms as they apply.</p>	

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	<p>least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 1 of 1 smoke barrier walls were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect at least 40 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and the Executive Director on 03/05/15 from 12:22 p.m. to 4:14 p.m., the following smoke barrier wall penetration and unsealed floor/corridor/ceiling penetrations were noted:</p> <p>a) two separate one eighth inch ceiling penetrations in the 3rd floor stairwell b) one and a half inch by twenty four inch ceiling penetration in the 3rd floor main stairwell c) one of four ceiling tiles missing in the</p>	K 0025	<p>It is the policy of this facility that smoke barriers are constructed to provide at least one half hour fire resistance rating in accordance with 8.3.</p> <p>What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <ol style="list-style-type: none"> <li>1. The two separate one eighth inch ceiling penetrations in the 3rd floor stairwell have been filled with fire rated caulk. (see attachment)</li> <li>2. The one and a half inch by twenty four inch ceiling penetration in the 3rd floor main stairwell has been filled with fire rated caulk. (see attachment)</li> <li>3. The 4 ceiling tiles have been replaced in the 2nd floor activity room. (see attachment)</li> <li>4. The one and a half inch ceiling tiles have been replaced in the coat room. (see attachment)</li> <li>5. The one inch floor penetration in the 1st floor linen storage room has been filled with fire rated caulk. (see attachment)</li> <li>6. The one half inch and the one eighth inch penetrations in the</li> </ol>	02/25/2016

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	<p>2nd floor Activity room d) one and a half of eleven ceiling tiles missing in the Coat room e) one inch floor penetration in the 1st floor Linen storage room f) one half inch and one eighth inch penetrations in the corridor outside Laundry g) one half inch and two separate one eighth inch corridor penetrations in the 2nd floor Nurse's station h) two inch by three inch piece of drywall removed from the 2nd floor Nurse's station smoke barrier wall Based on interview at the time of each observation, the Maintenance Director and the Executive Director acknowledged and provided the measurements for each unsealed penetration.</p> <p>3.1-19(b)</p>		<p>corridor outside of laundry have been filled with firerated caulk. (see attachment) 7.The one half inch and two separate one eighthinch corridor penetrations in the 2nd floor nurses station have beenfilled with fire rated caulk. (seeattachment) 8.The two inch by three inch piece of drywall inthe 2nd floor nurses station smoke barrier wall has beenreplaced. (see attachment) How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action (s)will be taken: The deficient practice had the potential to affect staff andat least 40 residents. The Maintenance Directoror designee inspected all floor, corridor, ceiling areas to ensure they weresealed in accordance with LSC 8.3.2. What measures will be put into place or what systemicchanges will be made to ensure that the deficient practice does not recur: 1.The two separate one eighth inch ceilingpenetrations in the 3rd floor stairwell have been filled with firerated caulk. (see attachment) 2.The one and a half inch by twenty four inchceiling penetration in the 3rd floor main stairwell has been filledwith fire rated caulk. (see attachment) 3.The 4 ceiling tiles have been</p>		

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			<p>replaced in the 2nd floor activity room. (see attachment)</p> <p>4. The one and a half ceiling tiles have been replaced in the coat room. (see attachment)</p> <p>5. The one inch floor penetration in the 1st floor linen storage room has been filled with fire rated caulk. (see attachment)</p> <p>6. The one half inch and the one eighth inch penetrations in the corridor outside of laundry have been filled with fire rated caulk. (see attachment)</p> <p>7. The one half inch and two separate one eighth inch corridor penetrations in the 2nd floor nurses station have been filled with fire rated caulk. (see attachment)</p> <p>8. The two inch by three inch piece of drywall in the 2nd floor nurses station smoke barrier wall has been replaced. (see attachment)</p> <p>The Maintenance Director or Designee will inspect after any projects are completed that could have the potential of causing a penetration to a smoke barrier on any floor, corridor, or ceiling. 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:</p> <p>The Maintenance Director or designee will inspect all floors, corridors and ceilings weekly for 4 weeks, monthly for 6 months and then after the completion of any</p>	

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K 0027 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 sets of fire barrier doors would close to form a smoke resistant barrier. This deficient practice could affect at least 27 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Executive Director on 01/26/16 at 2:47 p.m., the Entrance set of fire barrier doors had a three eighths inch gap between the doors and would not close to form a smoke resistive barrier. Based on interview at the time of observation, the Maintenance</p>	K 0027	<p>project thereafter. These inspections will be added to the PreventativeMaintenance program and will be recorded on the daily/weekly/monthly PM forms as they apply.</p> <p>It is the policy of this facility for door openings in smokebarriers have at least a 20 minute fire protection rating or are at lease 1 ¾inch thick solid bonded wood core. Non-ratedprotective plates that do not exceed 48 inches from the bottom of the door arepermitted. What corrective action (s) will be accomplished for thoseresidents found to have been affected by the deficient practice: The three eighths inch gap between the entrance set of firebarrier doors has been filled to form a smoke resistive barrier. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action (s)will be</p>	02/25/2016

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	<p>Director and the Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>taken:</p> <p>The deficient practice had the potential to affect staff, visitors and at least 27 residents.</p> <p>The Maintenance Director or designee inspected all door openings in smoke barrier to ensure that they offered a smoke barrier to the corridor in accordance with LSC. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The three eighths inch gap between the entrance set of fire barrier doors has been filled to form a smoke resistive barrier. The Maintenance Director or designee will inspect all door openings in smoke barriers to ensure that they offer a smoke barrier to the corridor weekly for 4 weeks and then monthly for 6 months.</p> <p>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:</p> <p>The Maintenance Director or designee will inspect all door openings in smoke barriers to ensure that they offer a smoke barrier to the corridor weekly for 4 weeks and then monthly for 6 months. These inspections will be added to the Preventative Maintenance program and will be recorded on the weekly and monthly PM forms as they apply.</p>	

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K 0029 SS=E Bldg. 01	<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>1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Shower room containing more than 32 gallons of hazardous soiled linen/trash, a hazardous area, would resist the passage of smoke. This deficient practice could affect staff and up to 40 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Executive Director on 01/26/16 at 12:31 p.m., the 3rd floor shower room door had a quarter inch penetrations that went through the door. Inside the shower room contained three separate containers of soiled linen. Based on interview at the time of observation, the Maintenance Director and the Executive Director acknowledged the aforementioned condition.</p>	K 0029	<p>It is the policy of this facility to have one hour firerated construction (with ¾ hour fire-rated doors) or an approved automatic fireextinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protectshazardous areas. What corrective action (s) will be accomplished for thoseresidents found to have been affected by the deficient practice:</p> <p>1.The quarter inch penetration in the 3rdfloor shower room door has been filled and the door now provides a smokebarrier. (see attachment)</p> <p>2.A self-closing device was installed on the HRstorage room door and it now self closes and latches into place. A self-closing device was installed on theBasement linen supply room door and it now self closes and latches intoplace.</p> <p>How other residents having the potential to be affected bythe same</p>	02/25/2016

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 HR storage room and 1 of 1 Basement Linen Supply greater than 50 square feet, a hazardous area, was provided with self-closer and would latch into the frame. These two deficient practices were not in patient care areas.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Executive Director on 1/26/16 at 1:12 p.m. then again 3:17 p.m., the HR storage room contained at least twenty nine large cardboard boxes full of paperwork. The door failed to self-close and latch when tested. Then again the Basement Linen Supply contained stacks of clean linen and twelve very large cardboard boxes containing linens and other combustible material. One of the three doors from the Basement Linen Supply room did not have a self-closing device. Based on interview at the time of each observation, the Maintenance Director and the Executive Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p>deficient practice will be identified and what corrective action (s) will be taken:</p> <p>The deficient practice had the potential to affect staff and at least 40 residents. The Maintenance Director or designee inspected all doors to ensure that if they lead to a hazardous area then they had self-closing devices and that they latched into the frame and that they provided a smoke barrier to the corridor.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>1. The quarter inch penetration in the 3rd floor shower room door has been filled and the door now provides a smoke barrier. (see attachment)</p> <p>2. A self-closing device was installed on the HR storage room door and it now self closes and latches into place. A self-closing device was installed on the Basement linen supply room door and it now self closes and latches into place.</p> <p>The Maintenance Director or designee will inspect all doors to ensure that if they lead to a hazardous area then they have self-closing devices and that they latch into the frame and that they provide a smoke barrier to the corridor weekly for 4 weeks and then monthly for 6 months.</p> <p>How the corrective action (s) will be</p>		

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K 0050 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure 12 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.2</p>	K 0050	<p>monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The Maintenance Director or designee will inspect all doors to ensure that if they lead to a hazardous area then they have self-closing devices and that they latch into the frame and that they provide a smoke barrier to the corridor weekly for 4 weeks and then monthly for 6 months. These inspections will be added to the Preventative Maintenance program and will be recorded on the weekly and monthly PM forms as they apply.</p> <p>It is the policy of this facility to ensure that fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning</p>	02/25/2016

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	<p>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.</p> <p>Findings include:</p> <p>Based on record review of titled "Monthly Fire Drill Report" with the Maintenance Director and the Executive Director on 01/26/16 at 9:43 a.m., the documentation for the drills failed to include verification of transmission of the fire alarm signal to the monitoring station. Based on interview at the time of record review, the Maintenance Supervisor was writing down the time he called the monitoring station to take the facility out of bypass, but did not document the facility had received the signal.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9PM and 6AM a coded announcement may be used instead of audible alarms. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: The Maintenance Director conducted a fire drill on _____ 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: The deficient practice had the potential to affect staff, guests and all residents. The Maintenance Director or designee ensured that the fire drill conducted on 1-26-16 was completed in accordance with 19.7.1.2. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director or designee will conduct all fire drills in accordance with 19.7.1.2 and the Executive Director or designee will review the documentation after each fire drill occurs. 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:</p>		

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K 0051 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6  Based on observation and interview, the facility failed to ensure 1 of 1 smoke detector in the 2nd floor nurse's station was not installed where air flow would	K 0051	The Maintenance Director or designee will conduct all fire drills in accordance with 19.7.1.2 and the Executive Director or designee will review the documentation after each fire drill occurs. These inspections will be added to the Preventative Maintenance program and will be recorded on the weekly and monthly PM forms as they apply and the Executive Director or designee will sign to indicate that they were reviewed.  It is the policy of this facility to have a fire alarm system with smoke detectors that are installed in such a way that air vents cannot prevent their operation.	02/25/2016	

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	<p>adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice was in the second floor where no resident was present.</p> <p>Findings include: Based on observation with the Maintenance Director and the Executive Director on 01/26/16 at 1:26 p.m., the 2nd floor nurse's station had a smoke detector located two and a half inches away from an HVAC vent. Based on interview at the time of observation, the Maintenance Director and the Executive Director acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p>		<p>What corrective action (s) will be accomplished for thoseresidents found to have been affected by the deficient practice: The Maintenance Director or designee capped the vent at the2nd floor nurses station and stopped any potential air flow to thevent thus prohibiting it from interfering with the operation of the smokedetector. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action (s)will be taken: The deficient practice had the potential to affect staffonly. The Maintenance Director ordesignee inspected all smoke detectors to ensure that they were installed inaccordance with NFPA 72. What measures will beput into place or what systemic changes will be made to ensure that the deficientpractice does not recur: The Maintenance Director or designee capped the vent at the2nd floor nurses station and stopped any potential air flow to thevent thus prohibiting it from interfering with the operation of the smokedetector. The Maintenance Director ordesignee will inspect all smoke detectors to ensure that there are no barriersthat could potentially interfere with their operation daily for 7 days, weeklyfor 4 weeks and then monthly for 6 months.</p>		

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K 0056 SS=E Bldg. 01	<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 the spray pattern for 1 of 1 sprinkler head in the 3rd floor Main Stairwell and 1 of 1 sprinkler head in the 2nd floor Nurses' station was</p>	K 0056	<p>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:</p> <p>The Maintenance Director or designee will inspect all smoke detectors to ensure that there are no barriers that could potentially interfere with their operation daily for 7 days, weekly for 4 weeks and then monthly for 6 months. These inspections will be added to the Preventative Maintenance program and will be recorded on the daily, weekly and monthly PM forms as they apply.</p> <p>It is the policy of this facility to ensure that there are no barriers that would obstruct the spray pattern of automatic sprinkler heads. What corrective action (s) will be accomplished for those residents</p>	02/25/2016

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	<p>unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could affect at least 20 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and the Executive Director on 1/26/16 at 12:40 a.m. then again at 1:15 p.m., the spray pattern for the sprinkler head in the Main Stairwell was obstructed by a ceiling light one and a half inches away and one eighth inches below the sprinkler head deflector. Then again, the spray pattern for the sprinkler head in the 2nd floor Nurse station was obstructed by a fan/ceiling light fans which was five inches below the sprinkler head deflector and extended past the sprinkler head. Based on interview at the time of each observation, the Maintenance Director and the</p>		<p>found to have been affected by the deficient practice:</p> <p>The Maintenance Director or designee relocated the light located in the main stair way so that it no longer has the potential to obstruct the spray pattern of the sprinkler head. The Maintenance Director or designee removed the ceiling fan blades located in the 2nd floor nurses station so that it no longer has the potential to obstruct the spray pattern of the sprinkler head. 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:</p> <p>The deficient practice had the potential to affect staff and 20 residents. The Maintenance Director or designee inspected all sprinkler heads to ensure that they were installed in accordance with NFPA 25.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The Maintenance Director or designee relocated the light located in the main stair way so that it no longer has the potential to obstruct the spray pattern of the sprinkler head. The Maintenance Director or designee removed the ceiling fan blades located in the 2nd floor nurses station so that it no longer has the potential to obstruct the spray pattern of the sprinkler head.</p>	

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K 0062 SS=C Bldg. 01	<p>Executive Director acknowledged the aforementioned conditions.</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>1. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems</p>	K 0062	<p>The Maintenance Director or designee will inspect all sprinkler heads to ensure that there are no barriers that could potentially obstruct their spray pattern daily for 7 days, weekly for 4 weeks and then monthly for 6 months.</p> <p>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:</p> <p>The Maintenance Director or designee will inspect all sprinkler heads to ensure that there are no barriers that could potentially obstruct their spray pattern daily for 7 days, weekly for 4 weeks and then monthly for 6 months. These inspections will be added to the Preventative Maintenance program and will be recorded on the daily, weekly and monthly PM forms as they apply.</p> <p>It is the policy of this facility to ensure that the automatic sprinkler system is continuously maintained in reliable operating condition and is inspected and tested periodically. What corrective action (s) will be accomplished for those residents found to have been affected by the</p>	02/25/2016	

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	<p>10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of sprinkler system documentation with the Maintenance Director on 01/26/16 at 10:20 a.m., none of the quarterly sprinkler system inspection and testing records indicated an internal inspection of the sprinkler system pipes had been conducted. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain sprinkler heads. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all</p>		<p>deficient practice:</p> <p>1. The Maintenance Director or designee ensured that the sprinkler system was inspected and tested on 7-17-2013. (see attachment)</p> <p>2.A. The corroded sprinkler head in the 2nd floor employee bathroom was replaced. (see attachment)</p> <p>B. The corroded sprinkler head in the 2nd floor janitors' closet was replaced. (see attachment)</p> <p>C. The 5 corroded sprinkler heads outside of the main entrance were replaced. (see attachment)</p> <p>D. The sprinkler head with the bent deflector in the walk in freezer was replaced. (see attachment)</p> <p>E. The corroded sprinkler head with paint on it in the dish room was replaced. (see attachment)</p> <p>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:</p> <p>The deficient practice had the potential to affect staff, visitors and all residents. The Maintenance Director or designee inspected all sprinkler heads to ensure that they were not corroded and did not have any paint on them. The Maintenance Director or designee inspected all documentation related to the sprinkler system inspections to ensure that it was present.</p>				

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	<p>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. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Executive Director on 01/19/16 between 1:17 p.m. and 3:03 p.m., the following sprinkler heads were not maintained:</p> <p>a) 1 of 1 2nd floor Employee Restroom was corroded b) 1 of 1 2nd floor Janitor's Closet was corroded c) 5 of 6 Main Entrance was corroded d) 1 of 1 Walk-in Freezer bend spray deflector e) 1 of 2 Dish Room was painted and corroded</p> <p>Based on interview at the time of each observation, the Maintenance Director and the Executive Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director or designee inspected all sprinklerheads to ensure that they were not corroded and did not have any paint on them. The Maintenance Director or designee inspected all documentation related to the sprinkler system inspections to ensure that it was present. The Maintenance Director or designee will inspect all sprinkler heads to ensure that they are not corroded and that they do not have paint on them daily for 7 days, weekly for 4 weeks and then monthly for 6 months. The Maintenance Director or designee will complete an inspection of documentation every 6 months for all inspections that occur every 2 years or more. 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: The Maintenance Director or designee will inspect all sprinkler heads to ensure that they are not corroded and that they do not have paint on them daily for 7 days, weekly for 4 weeks and then monthly for 6 months. The Maintenance Director or designee will complete an inspection of documentation every 6 months for all inspections that occur every 2</p>				

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K 0064 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>1. Based on observation and interview, the facility failed to ensure 3 of 4 2nd floor corridor and 4 of 4 1st floor corridor fire extinguishers in the Office was protected. NFPA 10, Standard for Portable Fire Extinguishers, Section 1-6.7 requires that portable fire extinguishers types shall be securely installed on the hanger or in the bracket supplied or placed in cabinets or wall recesses. The hanger or bracket shall be securely and properly anchored to the mounting surface in accordance with the manufacturer's instructions. 1-6.8 Fire extinguishers installed under conditions where they are subject to dislodgement shall be installed in brackets specifically designed to cope with this problem. 1-6.9 Fire extinguishers installed under conditions where they are subject to physical damage, (e.g., from impact, vibration, the environment) shall be adequately protected. This deficient practice could affect staff and up to 48 residents.</p>	K 0064	<p>years or more. These inspections will be added to the Preventative Maintenance program and will be recorded on the daily, weekly and monthly PM forms as they apply.</p> <p>It is the policy of this facility to ensure that portable fire extinguishers are provided in all areas in accordance with 9.7.4.1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>1.A. The 2nd floor East fire extinguisher was affixed to the wall. (see attachment) B. The 2nd floor North fire extinguisher was affixed to the wall. (see attachment) C. The fire extinguisher outside of room 233 was affixed to the wall. (see attachment) D. The fire extinguisher outside of room 117 was affixed to the wall. (see attachment) E. The fire extinguisher outside of room 113 was affixed to the wall. (see attachment) F. The fire extinguisher outside of room 105 was affixed to the wall. (see attachment) G. The fire extinguisher outside of room 132 was affixed to the wall. (see attachment) 2.A. The fire extinguisher</p>	02/25/2016

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Executive Director on 01/26/16 between 12:50 p.m. and 2:48 p.m., the following fire extinguishers were in cabinets but were not supported from tipping over:</p> <p>a) fire extinguisher in 2nd floor East Wing b) fire extinguisher in 2nd floor North Wing c) fire extinguisher outside of resident room 233 d) fire extinguisher outside of resident room 117 e) fire extinguisher outside of resident room 113 f) fire extinguisher outside of resident room 105 g) fire extinguisher outside of resident room 132</p> <p>Based on interview at the time of each observation, the Maintenance Director and the Executive Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 3rd floor West Wing and 1 of 1 Kitchen ABC portable fire extinguishers were installed</p>		<p>outside of room 326 was lowered. (see attachment) B. The fire extinguisher in the kitchen was lowered. (see attachment)</p> <p>3. The fire extinguisher outside of 113 was replaced with one that has full pressure (see attachment) 4. The fire extinguisher in the basement mechanical room was replaced with one that has full pressure. (see attachment)</p> <p>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:</p> <p>The deficient practice had the potential to affect staff, visitors and all residents. The Maintenance Director or designee inspected all fire extinguishers to ensure that they were affixed to the wall so that they could not tip over, at the proper height from the floor and at full pressure.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The Maintenance Director or designee inspected all fire extinguishers to ensure that they were affixed to the wall so that they could not tip over, at the proper height from the floor and at full pressure. The Maintenance Director or designee will inspect all fire extinguishers to ensure that they are</p>		

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	<p>correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect staff and 22 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Executive Director on 01/26/16 at 12:33 p.m. then again at 2:59 p.m., the fire extinguisher outside resident room 326 measured 64.5 inches from the top of the extinguisher to the floor. Then again the fire extinguisher in the kitchen measured 64 inches from the top of the extinguisher to the floor. Based on interview at the time of each observation, the Maintenance Director and the Executive Director acknowledged the aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguisher outside of resident room 113</p>		<p>affixed to the wall so that they cannot tip over, at the proper height from the floor and at full pressure daily for 7 days, weekly for 4 weeks and then monthly for 6 months.</p> <p>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:</p> <p>The Maintenance Director or designee will inspect all fire extinguishers to ensure that they are affixed to the wall so that they cannot tip over, at the proper height from the floor and at full pressure daily for 7 days, weekly for 4 weeks and then monthly for 6 months. These inspections will be added to the Preventative Maintenance program and will be recorded on the daily, weekly and monthly PM forms as they apply.</p>		

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	<p>pressure gauge readings was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect staff and up to 9 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Executive Director on 01/26/16 at 1:46 p.m., the gauge on the portable fire extinguisher located outside resident room 113 indicated the extinguisher was undercharged. Based on interview at the time of observation, the Maintenance Director and the Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>4. Based on observation and interview, the facility failed to ensure 1 of 1 Basement Mechanical Room fire extinguishers requiring a 12-year hydrostatic test was emptied and</p>			

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K 0069 SS=D Bldg. 01	<p>subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation and interview with the Maintenance Director and the Executive Director on 01/26/16 at 3:26 p.m., a Basement Mechanical Room fire extinguisher maintenance tag indicated the last six year test was completed 03/07. Based on interview at the time of observation, the Maintenance Director and the Executive Director acknowledged the aforementioned condition.</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 1. Based on record review and interview; the facility failed to ensure 1 of 1 range hood's fire extinguishing equipment was inspected and approved every 6 months by properly trained and qualified persons. LSC 9.2.3 refers to NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, in 8-2 requires the inspection and servicing of the fire</p>	K 0069	<p>It is the policy of this facility to ensure that all rangehood inspections are completed at least every 6 months and that range hoodshave blow off caps on all of their sprinkler heads.</p> <p>What corrective action (s) will be accomplished for thoseresidents found to have been affected by the deficient practice:</p> <p>1. The Range Hood was inspected on8-8-2015. (see</p>	02/25/2016

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	<p>extinguishing system and listed exhaust hoods containing a constant or fire actuated water system shall be made at least every 6 months by properly trained and qualified persons. NFPA 96, 8-2.1 requires all actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, and fire actuated dampers shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on review of the facility's Range Hood Inspection documentation with the Maintenance Director on 01/26/16 at 10:45 a.m., the most recent range hood fire extinguishing equipment inspection report was dated 2/17/15, however, there was no previous range hood fire extinguishing equipment inspection report available. During an interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 kitchen</p>		<p>attachment)</p> <p>2. A new blow off cap was installed on the rangehood sprinkler head. (see attachment)</p> <p>How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action (s)will be taken:</p> <p>The deficient practice had the potential to affect staffonly. The Maintenance Director ordesignee inspected all documentation related to range hood inspections. The Maintenance Director or designeeinspected the range hood to ensure that all of the blow off caps were present.</p> <p>What measures will be put into place or what systemicchanges will be made to ensure that the deficient practice does not recur:</p> <p>1. The Range Hood was inspected on8-8-2015. (see attachment)</p> <p>2. A new blow off cap was installed on the rangehood sprinkler head. (see attachment)</p> <p>The Maintenance Director or designee will inspect the rangehood to ensure that it has all of the blow off caps present daily for 7 days,weekly for 4 weeks and then monthly for 6 months. The Maintenance Director or designee willinspect the range hood inspection documentation monthly for 12 months and thenevery 3 months for 1 year.</p> <p>How the corrective action (s) will be</p>	

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	<p>range hood fire suppression system nozzles were provided with blowoff caps or other suitable devices to prevent the entrance of grease vapors into the nozzles. LSC 9.2.3 requires commercial cooking equipment to be in compliance with NFPA 96, 1998 Edition, the Standard for 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"> <li>a. NFPA 12, Standard on Carbon Dioxide Extinguishing Systems</li> <li>b. NFPA 13, Standard for the Installation of Sprinkler Systems</li> <li>c. NFPA 17, Standard for Dry Chemical Extinguishing Systems</li> <li>d. NFPA 17A, Standard for Wet Chemical Extinguishing Systems</li> </ul> <p>NFPA 17A, Standard for Wet Chemical Extinguishing Systems, 1998 Edition, 2-3.1.4 states all discharge nozzles shall be provided with caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign materials into the piping. The protection device shall blow off, open, or blow out upon agent discharge. This deficient</p>		<p>monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The Maintenance Director or designee will inspect the range hood to ensure that it has all of the blow off caps present daily for 7 days, weekly for 4 weeks and then monthly for 6 months. The Maintenance Director or designee will inspect the range hood inspection documentation monthly for 12 months and then every 3 months for 1 year. These inspections will be added to the Preventative Maintenance program and will be recorded on the monthly and quarterly PM forms as they apply.</p>	

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K 0075 SS=D Bldg. 01	<p>practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/26/16 at 2:57 p.m., one of five kitchen range hood fire suppression system nozzles were not provided with a blowoff cap or other suitable devices to prevent the entrance of grease vapors into the nozzles. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area which was not protected as a hazardous area for 1 of 1</p>	K 0075	<p>It is the policy of this facility to ensure that hazardous areas are protected by doors that have automatic closing devices and latch into their frame.</p> <p>What corrective action (s) will be accomplished for those residents found to have been affected by the</p>	02/25/2016

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	<p>Employee Suggestion Room. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Executive Director on 01/26/16 at 12:57 p.m., the Employee Suggestion Room contained a 40 gallon barrel of trash and a 32 gallon container of soiled linen. The door did not have a self-closing device installed. Based on interview at the time of observation, the Maintenance Director and the Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>deficient practice:</p> <p>The 40 and 32 gallon barrels were removed from the Employee Suggestion Room and is no longer a hazardous area.</p> <p>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:</p> <p>The deficient practice had the potential to affect staff only. The Maintenance Director or designee inspected all hazardous areas to ensure that their doors are equipped with automatic closing devices and latch in their frame.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The 40 and 32 gallon barrels were removed from the Employee Suggestion Room and is no longer a hazardous area.</p> <p>The Maintenance Director or designee will inspect all hazardous areas to ensure that their doors are equipped with automatic closing devices and latch in their frame daily for 7 days, weekly for 4 weeks and then monthly for 6 months.</p> <p>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:</p> <p>The Maintenance Director or designee will inspect all hazardous areas to ensure that their doors are</p>		

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K 0076 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 4 cylinders in Transfill Room of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only.</p>	K 0076	<p>equipped with automatic closing devices and latch in their frame daily for 7 days, weekly for 4 weeks and then monthly for 6 months. These inspections will be added to the Preventative Maintenance program and will be recorded on the daily, weekly and monthly PM forms as they apply.</p> <p>It is the policy of this facility to ensure that oxygen cylinders are stored off of the ground in the transfill room and that combustible materials be at least five feet from oxygen storage equipment. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>1. All staff were in-serviced on 2-12-2016 that they are to place oxygen cylinders in their holding stations when they are in the Transfill room. (see attachment)</p> <p>2. Placed oxygen cylinders in their holding stations. (see</p>	02/25/2016

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Executive Director on 01/26/16 at 2:27 p.m., the transfill room had two oxygen cylinders that were freestanding on the floor. Based on interview at the time of observation, the Maintenance Director and the Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in 1 of 1 transfill room. NFPA 99, 8-3.1.11.2(c) requires oxidizing gases such as oxygen shall be separated from combustibles by a minimum distance of five feet if the required storage location is protected by an automatic sprinkler system. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Executive Director on 01/26/16 at 2:27 p.m., the transfill room was constructed inside another room. The transfill area had two</p>		<p>attachment)</p> <p>3. Installed drywall over the wood studs in the Transfill room. 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:</p> <p>The deficient practice had the potential to affect staff only. The Maintenance Director or designee inspected all oxygen storage areas.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>1. All staff were in-serviced on 2-12-2016 that they are to place oxygen cylinders in their holding stations when they are in the Transfill room. (see attachment)</p> <p>2. Placed oxygen cylinders in their holding stations. (see attachment)</p> <p>3. Installed drywall over the wood studs in the Transfill room. The Maintenance Director or designee will inspect all oxygen storage areas to ensure that oxygen cylinders are in their holding stations and that there are no combustible materials within five feet of the oxygen storage area daily for 7 days, weekly for 4 weeks and then monthly for 6 months. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be</p>		

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K 0103 SS=D Bldg. 01	<p>cement walls from the facility, one created side of drywall, and one side with no drywall exposing wooden studs and was approximately three feet away from oxygen storage. Based on interview at the time of observation, the Maintenance Director and the Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3 Based on observation and interview, the facility failed to ensure interior walls in 1 of over 60 rooms in the facility were comprised of noncombustible or limited combustible materials. LSC 19.1.6.3 states all interior walls and partitions in buildings of Type I or Type II construction shall be of noncombustible or limited combustible materials. Exception: Listed, fire retardant treated wood studs shall be permitted within non-load bearing 1-hour fire rated partitions. This deficient practice could affect staff only.</p>	K 0103	<p>put into place: The Maintenance Director or designee will inspect all oxygenstorage areas to ensure that oxygen cylinders are in their holding stations andthat there are no combustible materials within five feet of the oxygen storagearea daily for 7 days, weekly for 4 weeks and then monthly for 6 months. These inspections will be added to thePreventative Maintenance program and will be recorded on the daily, weekly andmonthly PM forms as they apply.</p> <p>It is the policy of this facility to ensure that combustiblematerials be at least five feet from oxygen storage equipment. What corrective action (s) will be accomplished for thoseresidents found to have been affected by the deficient practice:A fire rated protective coating was sprayed over the wood studs and placed drywall over the fire rated protected wood studs in the Transfill room. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action (s)will be taken: The deficient practice had the potential to affect staff only.</p>	03/04/2016

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K 0130 SS=C Bldg. 01	<p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Executive Director on 01/26/16 at 2:27 p.m., the transfill room was constructed inside another room. The transfill room had no drywall on one oxygen storage side exposing wooden studs and was approximately three feet away from the oxygen storage. Based on interview at the time of observation, the Maintenance Director and the Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review and interview, the facility failed to ensure a battery</p>	K 0130	<p>The Maintenance Director or designee inspected all oxygen storage areas. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A fire rated protective coating was sprayed over the wood studs and placed drywall over the fire rated protected wood studs in the Transfill room. The Maintenance Director or designee will inspect all oxygen storage areas to ensure that there are no combustible materials within five feet of the oxygen storage area daily for 7 days, weekly for 4 weeks and then monthly for 6 months. 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: The Maintenance Director or designee will inspect all oxygen storage areas to ensure that there are no combustible materials within five feet of the oxygen storage area daily for 7 days, weekly for 4 weeks and then monthly for 6 months. These inspections will be added to the Preventative Maintenance program and will be recorded on the daily, weekly and monthly PM forms as they apply.</p> <p>It is the policy of this facility to ensure battery operated smoke</p>	02/25/2016	

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	<p>testing and replacement program was provided to ensure 66 of 66 single station smoke alarms would operate. This deficient practice affects all 116 residents.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 01/26/16 at 10:38 a.m., the facility recorded when batteries were replaced when needed when they were tested. Based on interview at the time of record review, the Maintenance Director acknowledged no battery replacement program was in effect.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the penetration in 2 of 2 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p>		<p>detectors are monitored to ensure that they function properly and to ensure that there are no penetrations in fire barriers.</p> <p>What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>1. Replaced 66/66 batteries in battery operated smoke detectors.</p> <p>2.A. Filled 2 inch by 6 inch and a 2 inch by 2 inch penetration in the 1st floor riser room with fire rated caulk. (see attachment)</p> <p>B. Filled 3 inch by 8 inch block gap in Basement fire barrier wall with block and fire rated caulk. (see attachment)</p> <p>C. Sealed 4 foot by 8 foot gap in basement fire wall where the wall is offset from the fire doors by placing two pieces of 4 foot by 8 foot 5/8' inches thick drywall stacked on one another in the ceiling between the firewall and the fire doors.</p> <p>D. Filled 1 inch by 1 inch in basement fire wall with fire rated caulk. (see attachment)</p> <p>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:</p> <p>The deficient practice had the potential to affect staff and 27 residents. The Maintenance Director or designee inspected all battery operated smoke detectors for function and all fire barriers to ensure that they are maintained</p>	

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	<p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect up to 27 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director and the Executive Director on 01/26/16 at 4:02 p.m. then again at 4:25 p.m., a two inch by six inch and a two inch by two inch penetration in the 1st Floor Riser Room fire wall above the drop ceiling. Then again, a three inch by eight inch block, three inch by eight</p>		<p>properly.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>1. Replaced 66/66 batteries in battery operated smoke detectors.</p> <p>2.A. Filled 2 inch by 6 inch and a 2 inch by 2 inch penetration in the 1st floor riser room with fire rated caulk. (see attachment)</p> <p>B. Filled 3 inch by 8 inch block gap in Basement fire barrier wall with block and fire rated caulk. (see attachment)</p> <p>C. Sealed 4 foot by 8 foot gap in basement fire wall where the wall is offset from the fire doors by placing two pieces of 4 foot by 8 foot 5/8' inches thick drywall stacked on one another in the ceiling between the firewall and the fire doors.</p> <p>D. Filled 1 inch by 1 inch in basement fire wall with fire rated caulk. (see attachment)</p> <p>The Maintenance Director or designee will inspect all battery operated smoke detectors for function and all fire barriers to ensure that they are maintained properly daily for weekly for 4 weeks and then monthly for 6 months.</p> <p>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:</p> <p>Maintenance Director or designee will inspect all battery operated</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155115		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED  01/26/2016	
NAME OF PROVIDER OR SUPPLIER  CARDINAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617			
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K 0147 SS=D Bldg. 01	<p>inch gap in between expandable foam, and one inch penetration in the Basement fire barrier wall. Additionally, the Basement fire barrier wall was offset with the doors. The horizontal distance between the fire wall barrier and the fire doors was four feet by eight feet. Based on interview at the time of each observation, the Maintenance Director and the Executive Director acknowledged each aforementioned condition, provided the measurements, and was unable to provide documentation for the expandable foam product.</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</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cord were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 3 residents.</p>	K 0147	<p>smoke detectors for function and use once a week for 4 weeks then once a month for 6 months and then all batteries will be changed every 6months. Maintenance Director or designee will inspect all fire barriers to ensure that they are maintained properly weekly for 4 weeks and then monthly for 6 months and then after any physical plant projects that have a potential to affect the integrity of their fire rating. These inspections will be added to the Preventative Maintenance program and will be recorded on the weekly and monthly PM forms as they apply.</p> <p>It is the policy of this facility to ensure that flexible cords are not utilized as a substitute for fixed wiring to provide power equipment with a high current draw and to maintain all electrical equipment so that there are no live parts exposed to contact. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <ol style="list-style-type: none"> <li>1.Plugged the Toaster oven and the Microwave into the wall and removed the surge protector.</li> <li>2.Installed an outlet cover on</li> </ol>	02/25/2016			

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	<p>Findings include:</p> <p>Based on observation with Maintenance Director and the Executive Director on 07/20/15 between 1:09 p.m., a surge protector was powering a toaster oven and microwave in Therapy. Based on interview at the time of observation, the Maintenance Director and the Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain an electrical outlet in 1 of 1 Customer Care Coordinator's office and 1 of 1 Medical Records office. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and the Executive Director on 10/13/15 at 11:52 a.m. then again at 12:08 p.m., a missing outlet cover in the Customer Care Coordinator's office. Then again a missing outlet cover in the Medical Records office. Based on</p>		<p>the outlets in boththe CCC office and the Medical Records office. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action (s)will be taken: The deficient practice had the potential to affect staffonly. The Maintenance Director ordesignee inspected all electrical equipment and wiring in order to ensure thatit is in compliance. What measures will be put into place or what systemicchanges will be made to ensure that the deficient practice does not recur:</p> <ol style="list-style-type: none"> <li>1.Plugged the Toaster oven and the Microwave intothe wall and removed the surge protector.</li> <li>2.Installed an outlet cover on the outlets in boththe CCC office and the Medical Records office. Maintenance Director or designee will inspect all electricalequipment and wiring in order to ensure that it is in compliance daily for 7days, weekly for 4 weeks and then monthly for 6 months. How the corrective action (s) will be monitored to ensurethe deficient practice will not recur, i.e., what quality assurance programwill be put into place: Maintenance Director or designee will inspect all electricalequipment and wiring in order to ensure that it is in compliance daily for 7days, weekly for 4 weeks and then monthly for 6 months. These inspections willbe added to the Preventative Maintenance</li> </ol>	

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	interview at the time of each observation, the Maintenance Director and the Executive Director acknowledged each aforementioned condition.  3.1-19(b)		program and will be recorded on the daily, weekly and monthly PM forms as they apply.		