

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2012
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NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN 46307
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/17/12</p> <p>Facility Number: 001198 Provider Number: 155637 AIM Number: 100471000</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Chicagoland Christian Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies, and 410 IAC 16.2.</p> <p>This facility was located on the west side of the first floor and the entire lower level of a two story</p>	K0000	<p>LONG TERM CARE DIVISION INDIANA STATAE DEPARTMENT OF HEALTH</p> <p>Preparation and execution of this response and plan of Correction does not constitute an admission agreement by the Provider of the truth of the facts allege or conclusions set forth in the statement of deficiencies.</p> <p>The plan of correction is prepared and/or executed solely because it is Required by the provisions of Federal and State Law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual.</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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	<p>building. The facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and resident rooms. The facility has the capacity for 144 and had a census of 137 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/22/12.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>			

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K0018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure there were no impediments to closing and latching doors protecting a corridor opening in 2 of 10 smoke compartments. This deficient practice affects staff, visitors and 20 residents in the B Hall smoke compartment and any of 20 or more residents in the upper level dining room smoke compartment.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 05/17/12 at 11:30 a.m., the corridor door for the lower level assisted dining room wedged on</p>	K0018	<p>K 018 1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. a. No residents or visitors were harmed by this practice.b. The corridor door for the lower level assisted dining room which wedged on the uneven floor was immediately re-balanced and is functioning correctly.c. The astragal on the door in the lower level assisted dining room was corrected by application of a door coordinator and now closes automatically during fire drills.d. All door wedges were immediately removed. 2. 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: a. All residents, staff and visitors have the potential to be affected.b.</p>	06/16/2012			

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	<p>the uneven floor when opened wide. The door was held there unless pulled closed. The maintenance director confirmed at the time of observation, the door would have to be pulled over the uneven floor close it.</p> <p>b. Based on observation with the maintenance director on 05/17/12 at 2:00 p.m., one of two doors in the self closing double corridor door set providing access to the lower level dining room was equipped with an astragal. One half of a door coordinator was attached to the door frame above the doors. When the door with the astragal closed first, the second door could not close and latch into the door frame because it hit the astragal. The door coordinator did not operate to close the doors in the proper sequence because one half of the device was missing. The maintenance director acknowledged at the time of observations, the door could not close into the door frame without a working door coordinator.</p> <p>c. Based on observation with the maintenance director on 05/17/12 at 4:00 p.m., one of two</p>		<p>The maintenance supervisor will re-check all double doors to ensure proper closing. All doors were reviewed to determine if any other doors were affected by propping with wooden wedge. No other doors found propped at this time. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a. The identified double door will be tested monthly and placed on the preventive maintenance checklist. b. Re-in-service staff regarding propping of self closing doors with wedges are not allowed. 4. 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. a. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective. All corrections will be completed by 6/16/12</p>	

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	<p>doors in the self closing double corridor door set to the chapel was prevented from closing by a wooden wedge. The maintenance director agreed at the time of observation, the wedge prevented the door to the unoccupied room from self closing.</p> <p>3.1-19(b)</p>			

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K0021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure access doors to hazardous areas such as the kitchen in 1 of 10 smoke compartments was held open only with a device which would allow the door to close automatically. This deficient practice affects visitors, staff and 20 residents in the upper level dining room adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/17/12 at 1:30 p.m., one of two self closing kitchen access doors was prevented from closing by a</p>	K0021	<p>K021</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. The wedge preventing the kitchen door from automatically closing was immediately removed and discarded.</p> <p>2. 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>a. The maintenance supervisor and HFA shall examine the facility for any other self-closing doors being prevented from closing.</p> <p>b. No other doors were found wedged.</p>	06/16/2012

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	<p>rubber wedge. The maintenance director agreed at the time of observation, the wedge prevented the door from closing.</p> <p>3.1-19(b)</p>		<p>3. 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>a. All staff will be in-serviced on not blocking or stopping self-closing doors.</p> <p>4. 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>a. The Maintenance director shall report any noted malfunction or blocking of self-closing doors to the Quality Assurance Committee monthly for six months. The Quality Assurance Committee shall review the report and provide suggestions if necessary</p> <p>5. What date the systemic changes will be completed. All changes will be complete by 6/16/12</p>		

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K0033 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>Based on observation and interview, the facility failed to ensure a door in 1 of 4 stairways maintained the one hour fire resistance of the stairway exit enclosure. This deficient practice affects visitors, staff, and 40 or more residents in the lower level B hall and upper level dining room smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/17/12 at 2:05 p.m., the exit stairway access door near the beauty shop had no fire rating. The maintenance director checked the door at the time of observation and agreed he could not determine the fire rating of the door.</p> <p>3.1-19(b)</p>	K0033	<p>K0033</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. Affected door near beauty shop was changed for a door properly fire rated.</p> <p>2. 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>a. All resident could be affected. b. The corrective action will benefit all.</p> <p>3. 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>a. Installation of the proper fire rated door will insure that the deficient practice will not recur.</p> <p>4. How the corrective action(s) will be monitored to ensure the</p>	06/16/2012

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			<p>deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>a. The Maintenance director shall report any further doors lacking fire rating to the Quality Assurance Committee monthly for six months. The Quality Assurance Committee shall review the report see that the door is replaced immediately.</p> <p>5. What date the systemic changes will be completed. Date of completion 6/16/12</p>	

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K0048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the evacuation of the smoke compartment, the types of fire extinguishers available, or the use of the K-class fire extinguisher in conjunction with the overhead hood system in the written fire plan for the protection of 137 of 137 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <p>(1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire</p> <p>The plan should include each type of fire extinguisher available and any special requirement for their</p>	K0048	<p>K048</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. No residents, staff or visitors were harmed by the practice.</p> <p>2. 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>a. All residents, staff or visitors have the potential to be affected by the practice.</p> <p>3. 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>a. The written health care fire safety plan will be revised by June 16, 2012 to include the mention of the K fire extinguisher in the kitchen and internal evacuation from one smoke compartment to another.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will</p>	06/16/2012

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	<p>usage. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Fire Policy and Procedure with the maintenance director on 05/15/2012 at 11:40 a.m., the evacuation plan did not address internal evacuation from one smoke compartment to another. An Evacuation Procedure in the disaster plan notes: "Depending on the location of the fire, residents may be evacuated to another portion of the building, rather than total community evacuation". No more direction is given to identify smoke compartments or where to evacuate and the preparation for such internal evacuation. In addition, the fire safety plan did not identify available fire extinguishers and address the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The maintenance director acknowledged at the time of</p>		<p>be put into place.</p> <p>a. To ensure ongoing compliance the new policy will be placed in the new employee orientation and inserviced to all staff annually.</p> <p>b. The updated fire policy will be discussed at the Quality Assurance Committee by June 16, 2012. The Quality Assurance Committee will make suggestions and changes as necessary in the policy which has been updated.</p>				

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	record review, these elements were not addressed in the fire plan. 3.1-19(b)				

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K0051 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure smoke detectors connected to the fire alarm system in 3 of 10 smoke compartments were properly separated from an air supply. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect visitors, staff, and 48 residents in Haven, Reclaim II and D hall smoke compartments.</p>	K0051	K0511. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a. No residents, staff or visitors were harmed by the practice. 2. 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. a. All residents, staff or visitors have the potential to be affected by the practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. a. All three smoke detectors will be relocated at a minimum of three feet to assure	06/16/2012			

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	<p>Findings include:</p> <p>Based on observation with the maintenance director on 05/17/12 between 1:15 p.m. and 4:35 p.m., upper level smoke detectors were located 18 inches from an air vent in the Haven exit stairway, 24 inches from an air vent in the corridor near room 139, and 12 inches from a vent in the Reclaim II stairway. The maintenance director confirmed the distance measurements and acknowledged at the time of observation, the air flow could affect the function of the smoke detectors.</p> <p>3.1-19(b)</p>		<p>separation from an air supply in Haven unit, Reclaim I and D hall. 4. 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. a. Proper relocation of smoke detectors in identified areas will assure that they are not affected by airflow which could prevent proper functioning of the detectors. b. The installation of the smoke detectors will be completed by June 16, 2012 and discussed at the Quality Assurance Committee. The Quality Assurance Committee will ask questions as they feel are appropriate.</p>				

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K0054 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>Based on record review and interview, the facility failed to ensure sensitivity test documentation for 3 of 247 smoke detectors was completed within a year of installation. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked</p>	K0054	<p>K054</p> <ol style="list-style-type: none"> 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. <ol style="list-style-type: none"> a. No residents, staff or visitors were harmed by the practice. 2. 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. <ol style="list-style-type: none"> a. All residents, staff or visitors have the potential to be affected by the practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. <ol style="list-style-type: none"> a. All smoke detectors were inspected 5/17/12 by ---Safe Care. 4. 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. 	06/16/2012

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	<p>sensitivity range it shall be tested using the following methods:</p> <p>(1) Calibrated test method.</p> <p>(2) Manufacturer's calibrated sensitivity test instrument.</p> <p>(3) Listed control equipment arranged for the purpose.</p> <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range.</p> <p>(5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector." This deficient practice affects visitors, staff and 68 residents in Reclaim II, C and D hall smoke compartments.</p> <p>Findings include:</p> <p>Based on a review of the 08/12/10 Sensitivity Test and</p>		<p>a. All maintenance staff in-serviced on K054 to avoid further issues</p> <p>5. What date the systemic changes will be completed.</p> <p>a. The Maintenance staff will utilize a monitoring tool to assure that compliance is maintained. The audits will be reviewed during the facility assurance quality assurance committee meeting, monthly for six months. Work completed by 5/17/12.</p>				

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	<p>Inspection Report for testing with the maintenance director on 05/17/12 at 12:05 p.m., three smoke detectors in the healthcare facility were replaced after they failed the sensitivity test. There was no record for a test of the new smoke detectors. The maintenance director called his testing contractor immediately and confirmed the testing had not been done. The contractor arrived at 3:30 p.m. to perform the overdue testing.</p> <p>3.1-19(b)</p>			

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K0062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 5 of 6 sprinkler heads in the laundry were free of corrosion and/or foreign materials, such as grime. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 20 or more residents in the lower level dining room which is in the same smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/17/12 at 1:40 p.m., four sprinkler heads in the laundry were covered with a gray fuzzy grime. The sprinkler head protecting the area behind the dryers was turning green, usually evidence of corrosion. The maintenance director agreed at the time of observations, the</p>	K0062	<p>K062</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. No residents, staff or visitors were harmed by the practice. Sprinklers identified as a concern have been cleaned/replaced as directed.</p> <p>2. 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>a. All sprinklers were inspected and no other concerns noted.</p> <p>3. 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>a. -----Reserve stock of 2 sprinkler heads of each temperature type obtained.</p> <p>b. Safe Care has been contacted to change identified sprinkler heads by 6/16/12</p> <p>c. Maintenance staff inserviced</p>	06/16/2012

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	foreign materials could affect the function of the sprinkler heads. 3.1-19(b)		on K062. 4. 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. a. The Maintenance director shall report any noted malfunction of sprinkler heads requiring replacement to the Quality Assurance Committee monthly for six months. The Quality Assurance Committee shall review the report and provide suggestions if necessary 5. What date the systemic changes will be completed. a. All work completed by 6/16/12	

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K0064 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to provide 1 of 1 portable K class fire extinguishers with a verification of service collar. NFPA 10, the Standard for Portable Fire Extinguishers, at 4-4.4.2 requires each extinguisher that has undergone maintenance which includes internal examination or has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch. Each extinguisher that has undergone</p>	K0064	<p>K064</p> <ol style="list-style-type: none"> 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. <ol style="list-style-type: none"> a. No residents, staff or visitors were harmed by the practice. 2. 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. <ol style="list-style-type: none"> a. All residents have the potential to be affected. All other fire extinguishers were inspected and no further problems noted. b. Allied Fire Company inspected all fire extinguishers and applied/replaced "Verification of Service collar on 6/1/12. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. <ol style="list-style-type: none"> a. ----Maintenance staff inserviced on K064. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., 	06/16/2012

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	<p>the six year maintenance procedure shall have a "Verification of Service Collar" around the neck of the extinguisher indicating date of 6 year maintenance. This deficient practice could affect visitors, staff and 20 or more residents kitchen/dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/17/12 at 1:25 p.m., the K-class portable fire extinguisher in the kitchen lacked a verification of service collar. The maintenance director immediately examined the bottom of the fire extinguisher and found it rusted and without any stamp or other evidence of when the fire extinguisher had been manufactured. He said there was there was nothing to identify when a six year service might be due.</p> <p>3.1-19(b)</p>		<p>what quality assurance program will be put into place.</p> <p>a. The Administrator/designee will utilize a monitoring tool from maintenance to assure compliance. The inspections will be discussed at the monthly Quality Assurance committee meeting for a total of six months.</p> <p>5. What date the systemic changes will be completed.</p> <p>a. Inservice of maintenance staff and inspection completed by 6/16/12.</p>	

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K0070 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to provide evidence 3 of 3 space heaters were equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice could affect occupants of the dining room smoke compartment with the capacity for more than 45 residents.</p> <p>Findings include:</p> <p>Based on interview with the maintenance director on 05/17/12 at 12:10 p.m., the use of space heaters was prohibited in the building. On 05/17/12 between 1:15 p.m. and 4:00 p.m. space heaters were found in the MDS, social services, and housekeeping director's offices. The maintenance director said at the time of observations, he had no idea the space heaters were there and could not provide</p>	K0070	<p>K070</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. All portable heaters have been removed by 6/3/12 from staff offices.</p> <p>2. 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>a. All residents and staff have the potential to be affected.</p> <p>3. 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>a. Staff educated on why the portable heaters are not allowed.</p> <p>4. 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>	06/16/2012

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	evidence heating elements would not exceed the 212 F degree limit. In addition, he could not provide a written policy for the prohibition or use of space heaters in the facility. 3.1-19(b)		a. The Administrator/designee and the Maintenance will do weekly walking rounds for one month and twice a month for one month and then monthly for a total of six months. All reports will be discussed at the monthly Quality Assurance Committee meetings for a total of six months. Any compliance issues will possibly extend the audit and be determined by the Quality Assurance Committee. 5. What date the systemic changes will be completed. a. Completion date: 6/16/12	