

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155775	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/09/2012
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NAME OF PROVIDER OR SUPPLIER  CUMBERLAND POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1051 CUMBERLAND AVE WEST LAFAYETTE, IN 47906
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/09/12</p> <p>Facility Number: 000547 Provider Number: 155775 AIM Number: 100267440</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Cumberland Pointe Health Campus was found not in compliance with Requirements for Participation in 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>The certified health care beds in</p>	K0000	<p>Survey Event ID: X5FM11</p> <p>The submission of this POC does not indicate an admission by Cumberland Pointe Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Cumberland Pointe Health Campus. The facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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>this facility are located on the east and west wings of a one story building determined to be of Type V (111) construction which is fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors and 23 west wing resident rooms. 19 west wing resident rooms are equipped with battery powered smoke detectors. The facility has the capacity for 71 and had a census of 69 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage, and in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except the areas noted in K-56.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on</p> <p>The facility was found not in</p>			

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	compliance with the aforementioned regulatory requirements as evidenced by the following:			

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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 doors protecting corridor openings in 1 of 9 smoke compartments. This deficient practice could affect 10 staff and any visitor or resident accessing facilities in the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/09/12 at 2:40 p.m., the corridor door to the break room was equipped with a kick down door stop. The maintenance director acknowledge the door was prevented from closing when</p>	K0018	<p>CORRECTIVE ACTION The kick stop on the door to the employee break room has been removed.</p> <p>IDENTIFY OTHER RESIDENTS No other doors with a kick stop were identified during the survey so no other residents would be potentially affected.</p> <p>MEASURES/SYSTEMIC CHANGES A preventative maintenance log has been created to audit monthly to ensure that doors protecting corridor openings have no impediment to closing. Any impediment noted will be corrected immediately.</p> <p>MONITORING CORRECTIVE ACTION The Director of Plant Operations will audit the preventative maintenance log monthly to ensure audits are completed appropriately and any impediments are corrected immediately. Results of the audit</p>	07/31/2012

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	the door stop was engaged.  3.1-19(b)		will be reported to the QA Committee monthly for six months.		

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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 2 of 8 doors to hazardous areas were held open only by devices which would cause the doors to close automatically upon activation of the fire alarm system. This deficient practice could affect 10 staff and any visitor or resident accessing facilities in the service corridor.</p> <p>Based on observation with the maintenance director on 07/09/12 at 2:30 p.m., double corridor access doors between the kitchen and service corridor were equipped with self closing devices equipped with special knobs designed to prevent the doors</p>	K0021	<p>CORRECTIVE ACTION The hold open closer arms on the kitchen doors have been removed and replaced with closer arms that will not let the door be held open. IDENTIFY OTHER RESIDENTS No other doors in an exit passageway, horizontal exit, smoke barrier or hazardous area enclosure were identified during the survey with hold open closer arms. No other residents would be potentially affected. MEASURES/SYSTEMIC CHANGES An in-service for maintenance staff is being held on code requirements that no doors in an exit passageway can be held open to prevent those doors from closing automatically. MONITORING CORRECTIVE ACTION The Director of Plant Operations will audit all doors in exit</p>	08/03/2012			

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	from closing. The maintenance director acknowledged at the time of observation, this feature would prevent the doors from automatically closing when used.  3.1-19		passageways, horizontal exits, smoke barriers and hazardous area enclosures monthly to ensure no devices have been added to doors that would prevent them from self-closing. Results of the audit will be reported to the QA Committee monthly for six months.		

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K0025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at 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 openings through ceiling and wall smoke barriers in 2 of 9 smoke compartments were maintained to provide the 1/2 hour smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with an approved material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors, staff and 19 residents on the Pines Unit.</p>	K0025	<p>CORRECTIVE ACTION All penetrations or openings noted in smoke barriers during the survey have been sealed with an approved fire rated caulk sealant. IDENTIFY OTHER RESIDENTS A sweep of the entire building was conducted and no other penetrations or openings in smoke barriers were noted. No other residents would potentially be affected.</p> <p>MEASURES/SYSTEMIC CHANGES All plant operations staff will be in-serviced regarding the need for ensuring that any new penetrations in a smoke barrier must be filled with a fire rated caulk sealant. An audit form has been created to document the monthly inspection of smoke barriers to ensure no penetrations are observed and that any penetrations found are sealed immediately with the fire rated caulk sealant.</p> <p>MONITORING CORRECTIVE ACTION The Director of Plant</p>	08/08/2012	

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	<p>Findings include:</p> <p>Based on observation with the maintenance director on 07/09/12 between 11:45 a.m. and 3:30 p.m., two, half inch ceiling holes and conduit penetrating the ceiling in the ice machine room were unsealed; a half inch gap was unsealed around conduit penetrating the ceiling at the residential nurses station located in an area accessible to health care residents, a pipe penetration of the ceiling behind the laundry dryers was unsealed into the attic above, and a wall penetration in laundry was filled with expandable foam. The maintenance director acknowledged at the time of observations, the penetrations had not been properly sealed.</p> <p>3.1-19(b)</p>		<p>Operations will audit the monthly inspection of smoke barriers to ensure the inspections are taking place and any issues noted are corrected immediately. Results of the audit will be reported to the QA Committee monthly for six months.</p>		

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to provide automatic door closers on 3 of 8 doors providing access to hazardous areas. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff, and 19 residents on the Pines unit.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 07/09/12 at 1:45 p.m., two doors between the resident dining room and kitchen had no self closers. The maintenance director</p>	K0029	<p>CORRECTIVE ACTION 1) Self closing door closers have been added to the three doors noted on the survey (2 doors between the kitchen and Assisted Living dining room and to the Assisted Living shower room). 2) A self-closing door closer has been added to the door to the biohazard storage room. IDENTIFY OTHER RESIDENTS All doors in the campus were inspected during the survey and no other doors were noted lacking self-closers so no other residents would potentially be affected. MEASURES/SYSTEMIC CHANGES All plant operations staff will be in-serviced regarding the need to ensure that all doors separating spaces for smoke resistance have self-closers to ensure the doors close. An audit form has been created to document the monthly inspection of doors separating spaces for smoke resistance to ensure the doors have self-closers that work</p>	08/08/2012

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	<p>acknowledged at the time of observation, the doors were not self closing.</p> <p>b. Based on observation with the maintenance director on 07/09/12 at 2:00 p.m., the residential shower room was used for the storage of two half filled linen and trash receptacles. The door providing access to the area was not equipped with a self closer. The maintenance director said at the time of observation, he was not aware the room required a self closing door.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 8 doors to a hazardous area would self close. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice could affect 10 staff and any visitor or resident</p>		<p>and ensure the doors close. Any doors found not closing automatically will be corrected immediately. MONITORING CORRECTIVE ACTION The Director of Plant Operations will audit the monthly inspection of doors separating spaces for smoke resistance to ensure the inspections are taking place and any issues noted are corrected immediately. Results of the audit will be reported to the QA Committee monthly for six months.</p>	

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	<p>accessing facilities in the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/09/12 at 2:35 p.m., the self closing door to the biohazard storage room did not self close. The maintenance director acknowledged at the time of observation, the spring hinges designed to close the door were not doing the job.</p> <p>3.1-19</p>			

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K0038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure door latches for 4 of 4 rooms could be readily opened with a single operation. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one which is familiar to the average person. For example, a two step release, such as a knob and independent dead bolt, is not acceptable. In most occupancies, it is important a single action unlatch the door. This deficient practice could affect visitors, staff and 19 residents on the Pines Unit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/09/12 between 11:45 a.m. and 3:30 p.m., doors serving the break room and laundry, and two</p>	K0038	<p>CORRECTIVE ACTION The deadbolt locks have been removed and a new keyed lockset has been installed on the employee break room door, the laundry room door, and the two storage room doors to ensure exit passage with one operation to open the door. IDENTIFY OTHER RESIDENTS All doors in the campus were inspected during the survey and no other doors were found to have locks requiring more than one operation to open the door. No other residents would potentially be affected.</p> <p>MEASURES/SYSTEMIC CHANGES All plant operations staff will be in-serviced regarding the need to ensure that all doors have locks requiring only one operation to open the door. An audit form has been created to document the monthly inspection of doors to ensure that the doors have single operation to open. Any doors found with deadbolts or more than one operation to open will be corrected immediately.</p> <p>MONITORING CORRECTIVE ACTION The Director of Plant Operations will audit the monthly inspection of doors requiring one operation only to open to ensure the inspections are taking place and any issues noted are</p>	08/08/2012	

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	<p>storage room doors in the residential assisted living unit which is not separated from the Pines health care unit each had a deadbolt lock and door knob operating positive latches. In order to open the doors, the door knob and the dead bolt had to be turned. The maintenance director acknowledged at the time of observation, the arrangement required two operations to open the doors.</p> <p>3.1-19(b)</p>		<p>corrected immediately. Results of the audit will be reported to the QA Committee monthly for six months.</p>		

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K0050 SS=F	<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 conduct fire drills using the audible fire alarm during 1 of the past 4 quarters. LSC 19.7.1.2 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal. When drills are conducted between 00 p.m. and 6:00 a.m., a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on a review of Fire Drills with the maintenance director on 07/09/12 at 2:35 p.m., a fire drill was conducted at 8:00 p.m. during the third quarter of 2011 during the time frame which</p>	K0050	<p>CORRECTIVE ACTION The noted fire drill was held in 2011 and cannot be corrected.</p> <p>IDENTIFY OTHER RESIDENTS All fire drills conducted in the past year were reviewed and all fire drills affect all residents in the campus. MEASURES/SYSTEMIC CHANGES All plant operations staff will be in-serviced regarding the need to ensure that silent drills are only conducted between 9pm and 6am. The Fire Drill schedule and fire drill report form have been reviewed to include a notation that silent drills can only be held between 9pm and 6am.</p> <p>MONITORING CORRECTIVE ACTION The Executive Director will audit fire drill reports monthly to ensure silent drills are held only during the appropriate times per code. Results of the audit will be reported to the QA Committee monthly for six months.</p>	08/03/2012			

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	audible fire alarms are required. The maintenance director said at the time of record review, he conducted a silent drill because he didn't want to bother the residents.  3.1-19(b) 3.1-51(c)			

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K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 provide complete sprinkler coverage for 2 of 9 smoke compartments in a one story building of Type V (111) construction. LSC 19.1.6.2 requires one story facilities of Type V (111) construction be provided with complete sprinkler protection. This deficient practice affects residents, staff, and 19 or more residents in the Pines and service corridor smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on</p>	K0056	<p>CORRECTIVE ACTION The alcoves noted in the survey have been in existence for many years. The alcoves above the vending machine and in the Pines hallway near room 326 have been enclosed with appropriately rated materials and per the sprinkler company contractor the sprinkler system now provides proper protection for those areas as no alcoves or voids are present. For the alcove in the kitchen above the commercial toaster a sprinkler head is being added to ensure proper protection for that open alcove area. IDENTIFY OTHER RESIDENTS All ceilings in the campus were inspected during survey and no other alcoves or areas of the campus were noted to be without sprinkler protection so no other residents would be affected.</p> <p>MEASURES/SYSTEMIC CHANGES All plant operations</p>	08/08/2012

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	<p>07/09/12 between 11:45 a.m. and 3:30 p.m., sprinkler protection was not provided for the eleven by two foot vending alcove separated from the service corridor by a sixteen inch bulkhead; the commercial toaster alcove in the kitchen, and the west side of the fire door near room 326 which was separated from the adjacent corridor by a six inch bulkhead. The bulkhead left a two foot section of the corridor unprotected by the nearest sprinklers. The maintenance director acknowledged at the time of observation, these areas were not protected by the other sprinklers in the areas.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>staff will be in-serviced regarding the need to ensure all areas of the campus are protected with proper sprinkler protection. MONITORING CORRECTIVE ACTION Any physical plant changes where wall and ceiling partitions would be adjusted that could potentially affect sprinkler protection will be reviewed by the facility's contracted sprinkler company prior to work being initiated to ensure the changes do not affect sprinkler system protection for the area.</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>1. Based on observation and interview, the facility failed to ensure 1 of 4 Pines Unit shower room sprinkler heads was free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice could affect staff and 19 residents on the Pines Unit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/09/12 at 2:00 p.m., the resident shower room curtain was installed three inches from the ceiling which prevented the sprinkler head spray reaching the enclosed space. The maintenance</p>	K0062	<p>CORRECTIVE ACTION 1) A new shower curtain with approved mesh material has been ordered for the Pines shower room to ensure the sprinklers are free of obstruction in the room. 2a) The escutcheon in the Social Service office has been repaired. 2b) The three laundry room sprinklers heads have been cleaned to ensure they are free of obstruction. IDENTIFY OTHER RESIDENTS A sweep of the entire building was conducted and no other sprinkler heads are obstructed, missing escutcheons or in need of cleaning to ensure proper functioning so no other residents would potentially be affected.</p> <p>MEASURES/SYSTEMIC CHANGES A Preventative Maintenance checklist has been created that will require all sprinkler heads in the building are inspected monthly to ensure they are clean and in proper repair and working order and free of obstructions that could affect the spray pattern. Any concerns noted will be corrected immediately. MONITORING CORRECTIVE ACTION The Director of Plant Operations will audit the monthly inspection</p>	08/08/2012			

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	<p>director acknowledged at the time of observation, the shower curtain was closer than the minimum distance allowed between a sprinkler head and obstruction.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure sprinkler heads providing protection in 2 of 9 smoke compartments were maintained. This deficient practice could affect all staff, visitors and residents in the center smoke compartment which includes the chapel.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 07/09/12 at 12:05 p.m., the sprinkler head escutcheons was missing from the sprinkler head in the social services office. The maintenance director acknowledged at the time of observation, the missing escutcheon was a part of the sprinkler assembly.</p> <p>b. Based on observation with the maintenance director on</p>		<p>of sprinkler heads and any issues to ensure immediate corrections are made. Results of the audit will be reported to the QA Committee monthly for six months.</p>		

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	<p>07/09/12 at 2:50 p.m., three sprinkler heads protecting the the laundry were covered with a fuzzy gray material. The maintenance director acknowledged the at the time of observation, the sprinkler heads were not clean.</p> <p>3.1-19(b)</p>			

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K0143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 electrical outlets in the oxygen storage and transfer room were located at least five feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage. This deficient practice could affect staff, visitors and 19 residents on the Pines</p>	K0143	<p>CORRECTIVE ACTION The two electrical outlets noted in the oxygen storage and transfer room were removed and blank covers were placed over the openings. IDENTIFY OTHER RESIDENTS Transferring of oxygen only occurs in the room inspected during the survey so no other residents would have the potential to be impacted. MEASURES/SYSTEMIC CHANGES All plant operations staff will be in-serviced regarding the need for electrical outlets in the room where oxygen transfer takes place to be located at least five feet above the floor to avoid physical damage. MONITORING CORRECTIVE ACTION Any electrical outlet additions or changes in the oxygen storage room will be reviewed by the Director of Plant Operations and</p>	08/03/2012			

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	<p>Unit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/09/12 at 2:15 p.m., two electrical outlets in the oxygen transfer and storage room were located 46 inches above the floor. The maintenance director acknowledged at the time of observation, the electrical wall outlets were less than five feet above the floor.</p> <p>3.1-19(b)</p>		<p>the Executive Director prior to initiation of changes to ensure all electrical outlets remain more than five feet above the floor in compliance with the code.</p>		

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K0147 SS=B	<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 2 of 4 electrical equipment rooms were provided with sufficient access and working space to permit ready and safe operation and maintenance of the equipment. NFPA 70, Article 110.26 requires sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Table 110.26 (A)(1) requires a minimum of three feet of clear distance from the electrical equipment. This deficient practice could affect mainly staff in the two mechanical/electrical rooms.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 07/09/12 at 3:10 p.m., a floor cleaning machine blocked access to electrical circuit panels in the mechanical/electrical room</p>	K0147	<p>CORRECTIVE ACTION All equipment including the floor cleaning machine and the housekeeping cart have been removed from the electrical equipment rooms. IDENTIFY OTHER RESIDENTS A sweep of the entire building was conducted and no other electrical equipment rooms had access obstructed within three feet of the electrical equipment so no other residents would potentially be affected. MEASURES/SYSTEMIC CHANGES All plant operations staff will be in-serviced regarding the need for ensuring that a three foot area is maintained free of obstruction in all electrical equipment rooms. An audit form has been created to document the monthly inspection of the electrical equipment rooms to ensure they remain free of obstruction within three feet of the electrical equipment. Any concerns noted will be corrected immediately. MONITORING CORRECTIVE ACTION The Director of Plant Operations will audit the monthly inspection of electrical equipment rooms and ensure that any issues noted are corrected immediately. Results of the audit will be reported to the QA Committee monthly for six months.</p>	08/03/2012

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	<p>housing emergency generator electrical circuit panels. The maintenance director agreed at the time of observation, the circuit panels were not accessible.</p> <p>b. Based on observation with the maintenance director on 07/09/12 at 3:20 p.m., a housekeeping cart blocked access to electrical circuit panels in the mechanical/electrical room near the comprehensive care nurses station. The maintenance director agreed at the time of observation, the electrical circuit panels were not accessible.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure electrical cords in 1 of 9 smoke compartments was maintained. LSC 19.1.1.3 requires health care facilities shall be maintained to minimize the possibility of a fire emergency. This deficient practice could affect 10 or more visitors, staff or residents accessing the vending machines in the service corridor.</p>			

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	<p>Findings include:</p> <p>Based on observation with the maintenance director on 07/09/12 at 3:00 p.m., the cord providing power to one vending machine in the service corridor alcove was frayed between the cord and plug junction exposing the wires beneath the covering. The maintenance director agreed at the time of observation, the cord was not in good condition.</p> <p>3.1-19(b)</p>						