

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E594	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2015
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NAME OF PROVIDER OR SUPPLIER MCGIVNEY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 E 136TH ST CARMEL, IN 46033
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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: 07/22/15</p> <p>Facility Number: 000545 Provider Number: 15E594 AIM Number: 100267350</p> <p>At this Life Safety Code survey, McGivney Health Care 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 one story facility with a lower level was determined to be of Type V (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 hard wired smoke detectors in all resident rooms. The facility has a capacity of 37 and had a census of 31 at the time of this survey.</p>	K 0000	<p>Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under Federal and State law. The facility respectfully requests a desk review to determine compliance.</p>	
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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=F Bldg. 01	<p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one detached storage building and one electrical closet which were not sprinklered.</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. Based on observation and interview, the facility failed to ensure the vertical opening was protected with a one hour fire rated door. This deficient practice could affect all residents on first floor as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 7/22/15 at 1:00 p.m. the stairway fire door separating the basement from the first floor had a</p>	K 0020	<p>K020 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.</p> <p>Corrective action for residents affected: The stairway fire door separating the basement from the first floor has been replaced with a door that has a one-hour fire rating. Other residents having the</p>	08/21/2015

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K 0025 SS=F Bldg. 01	<p>twenty minute fire rating. Based on interview concurrent with the observation with the Maintenance Supervisor it was acknowledged the fire door was only a twenty minute door and needed to be a one hour fire rating.</p> <p>3.1-19(b)</p> <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</p>		<p>potential to be affected and corrective actions: All residents have the potential to be affected by this alleged deficient practice. A facility-wide inspection of all fire doors has been completed, and all meet the fire resistance rating. Measures to ensure practice does not recur: The regional director of facilities maintenance will be responsible for ensuring that the required fire resistance rated door is installed during all future facility construction or renovation. This corrective action will be monitored by: The Maintenance Supervisor or designee will monitor proper function of the stairway fire door separating the basement from the first floor weekly. Results will be documented and reviewed by the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date August 21, 2015</p>		

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	<p>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 observations and interview, the facility failed to ensure 2 of 3 smoke compartments were protected with smoke barriers which maintained the one half hour fire resistance rating of the smoke barrier. LSC Section 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier. This deficient practice could affect all residents as well as any staff and visitors if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observation on 07/22/15 during the tour between 11:00 a.m. and 4:00 p.m. with the Maintenance Supervisor, the following smoke barriers had unprotected gaps or holed which were not filled with a fire rated material to restrict the lateral movement of smoke from the rooms:</p> <p>a. The furnace room on long hall had a three quarters gap around the exhaust pipe going through the ceiling.</p>	K 0025	<p>K025</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3.</p> <p>Corrective action for residents affected:</p> <p>a. An escutcheon plate has been affixed to the gap around the exhaust pipe going through the ceiling in the furnace room..</p> <p>b. The three inch diameter opening in the fire wall around the sprinkler pipe in the attic has been filled with fire-rated calking.</p> <p>c. An escutcheon plate has been affixed around the sprinkler head in the coat closet on the short hall to enclose the gap.</p> <p>d. A larger escutcheon plate has been affixed to the ceiling in the laundry chute room to enclose the gap.</p> <p>e. A larger escutcheon plate has been affixed to the ceiling in the soiled utility room on the long hall to enclose the gap.</p> <p>Other residents having the potential to be affected and corrective actions:</p> <p>All residents have the potential to be affected by this alleged deficient practice. A facility-wide inspection has been completed, and all protrusions have adequate</p>	08/21/2015			

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K 0029 SS=E Bldg. 01	<p>b. The fire wall had a three inch diameter opening around a four inch diameter sprinkler pipe in the attic on the east side of the wall just south of social services office.</p> <p>c. The coat closet on short hall lacked an escutcheon around the sprinkler head which left a half inch gap around the sprinkler.</p> <p>d. The laundry chute room on long hall had a one inch gap around the escutcheon attached to the ceiling.</p> <p>e. The soiled utility room on long hall had a one half inch gap around the escutcheon plate attached to the ceiling.</p> <p>Based on interview on 07/22/15 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned areas had openings in the smoke barrier walls which were not sealed with fire caulk or an escutcheon to provide a fire/smoke resistant barrier.</p> <p>3.1-19(b)</p> <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</p>		<p>smoke barrier protection.</p> <p>Measures to ensure practice does not recur: The weekly maintenance environmental audit form has been revised to include observation of all protrusions to ensure adequate smoke barrier protection.</p> <p>This corrective action will be monitored by: The Maintenance Supervisor or designee will monitor that adequate smoke barriers are affixed over any protrusions weekly. Results will be documented and reviewed by the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date August 21, 2015</p>		

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	<p>separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 doors to hazardous areas such as the kitchen would self close and latch securely into its frame and resist the passage of smoke. This deficiency could affect 7 residents observed in the Main dining room which is adjacent to the kitchen as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 07/22/15 at 12:45 p.m. with the Maintenance Supervisor, the door which separates the kitchen from long hall was equipped with a self closing device, but would not self close the door and latch into its frame. Several attempts were made to test the door and it would not close completely and latch into its door frame. Also, the kitchen door leading into the dining room is a Dutch door and has a one half inch gap between the two halves and would not resist the passage of smoke. Based on interview on 07/22/15 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned kitchen doors did not</p>	K 0029	<p>K029</p> <p>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.</p> <p>Corrective action for residents affected:</p> <p>The self-closing device has been replaced with an automatic door closure on the kitchen door leading into the long hall. A fire rated smoke barrier has been affixed to the gap in the Dutch door from the kitchen into the dining room.</p> <p>Other residents having the potential to be affected and corrective actions:</p> <p>All residents have the potential to be affected by this alleged deficient practice. A facility-wide inspection of all hazardous areas has been completed and all smoke-resisting doors are functioning properly and have no gaps.</p> <p>Measures to ensure practice does not recur:</p> <p>The weekly maintenance environmental audit form has been revised to include observation of all self-closing door devices and/or gaps in doors</p>	08/21/2015

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K 0038 SS=E Bldg. 01	<p>either self close and latch into its frame or resist the passage of smoke.</p> <p>3.1-19(b)</p> <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 1 of 1 employee restrooms on short hall was not equipped with a slide bolt to latch the door from the inside. This deficient practice could affect any resident as well as visitors and staff if the occupants were inaccessible when the doors were latched from the inside.</p> <p>Findings include:</p> <p>Based on observation on 07/22/15 at 3:15 p.m. with the Maintenance Supervisor,</p>	K 0038	<p>that protect hazardous areas.</p> <p>This corrective action will be monitored by: The Maintenance Supervisor or designee will audit the function of the automatic door closure and the Dutch door weekly. Results will be documented and reviewed by the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date August 21, 2015</p> <p>K038 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1.</p> <p>Corrective action for residents affected: All slide bolts have been removed from restroom doors to ensure exit access.</p> <p>Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this alleged deficient practice. A facility-wide inspection completed and all restroom doors have had slide</p>	08/21/2015	

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K 0046 SS=E Bldg. 01	<p>the employee restroom on short hall had a slide bolt on the inside of the door when in the locked position could not be opened by staff to evacuate the occupants in an emergency. Based on interview concurrent with the observation it was acknowledged by the Maintenance Supervisor when the slide bolt locks was engaged inside the employee restroom the occupant could be trapped inside if they required assistance from staff during an emergency and it was further stated it should be removed.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1. Based on interview and observation, the facility failed to provide exterior emergency lighting for 1 of 6 exits on first floor. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect 22 residents as well as staff and visitors if the occupants in the</p>			K 0046	<p>bolts removed to ensure exit access.. Measures to ensure practice does not recur: The regional director of facilities maintenance will be responsible for ensuring that exits are accessible during all future facility construction or renovation. This corrective action will be monitored by: The Maintenance Supervisor or designee will observe exit access weekly. Results will be documented and reviewed by the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date August 21, 2015</p> <p>K046 Emergency lighting of at least 11/2 hour duration is provided in accordance with 7.9. Corrective action for residents affected: Emergency lighting has been installed in the exterior patio exit walkway. Other residents having the potential to be affected and</p>		08/21/2015

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K 0050 SS=F Bldg. 01	<p>facility were required to evacuate in an emergency.</p> <p>Findings include:</p> <p>Based on observation on 07/22/15 at 1:59 p.m. with the Maintenance Supervisor there was no lighting, emergency or otherwise for the patio exit walkway which discharged onto the parking lot. Based on interview on 07/22/15 at 2:00 p.m. with the Maintenance Supervisor it was acknowledged the patio walkway exit discharge lacked exterior emergency lights to illuminate walkway during a power outage.</p> <p>3.1-19(b)</p> <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</p>		<p>corrective actions: All residents have the potential to be affected by this alleged deficient practice. All means of egress have been inspected and emergency lighting is in place and functioning.</p> <p>Measures to ensure practice does not recur: Emergency lighting at all facility exits will continue to be monitored during routine scheduled inspections per the liability insurance company representatives, as well as the state and local fire inspectors.</p> <p>This corrective action will be monitored by: The Maintenance Supervisor will observe emergency lighting for proper function weekly. Results will be documented and reviewed by the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date August 21, 2015</p>		

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	<p>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 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 2 of 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports on 07/22/15 at 3:14 p.m. with the Maintenance Supervisor, the documentation for the drills performed between the hours of 6:00 a.m. and 9:00 p.m. for the past twelve months, from 07/2014 to 07/2015 indicated the fire alarm system had not been activated so the verification of the transmission of the signal could not be documented. Based on interview concurrent with record review it was acknowledged the first and second quarter of 2015 could not document the transmission of the signal was received by the monitoring station.</p>	K 0050	<p>K050</p> <p>Fire drills are held at unexpected times under varying conditions at least quarterly on each shift....Where drills are conducted between 9pm and 6am a coded announcement may be used instead of audible alarms.</p> <p>Corrective action for residents affected:</p> <p>Unable to correct the fire drills that lacked documentation of an audible alarm.</p> <p>Other residents having the potential to be affected and corrective actions:</p> <p>All residents have the potential to be affected by this alleged deficient practice. Drills have been conducted with activation of the audible fire alarm.</p> <p>Measures to ensure practice does not recur:</p> <p>Alarm activation will be documented during future fire drills conducted between 6AM and 9PM. Facility policy has been revised to include this requirement. The Maintenance Supervisor has been in-serviced on the policy.</p> <p>This corrective action will be monitored by:</p> <p>The regional director of facilities maintenance or designee will review fire drill documentation at least monthly to ensure audible alarms are activated as required.</p>	08/21/2015			

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K 0054 SS=F Bldg. 01	<p>3.1-19(b) 3.1-51(c)</p> <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 Based on record review and interview, the facility failed to ensure 2 of 65 smoke detectors had been tested to ensure the detectors were within their listed and marked sensitivity range. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2.1 requires that each smoke detector be within its listed and marked sensitivity range by testing using either: (a) A calibrated test method, or (b) The manufacturer's calibrated and sensitivity test instrument, or (c) Listed control equipment arranged for that purpose, or (d) A smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable</p>	K 0054	<p>The Executive Director will be informed of any drills that have not met the requirement, and will ensure that the drill is conducted. Completion Date August 21, 2015</p> <p>K054 All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. Corrective action for residents affected: The correct total count of smoke detectors installed in the facility is 63. Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this alleged deficient practice. The current vendor responsible for the fire alarm system has corrected the total count, and has tested and verified that all are functioning properly. Measures to ensure practice does not recur: The facility contract with a</p>	08/21/2015

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	<p>sensitivity range, or (e) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. Smoke detector sensitivity shall be checked within one year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended not to exceed five years. NFPA 72, 7-5.2 requires that inspection, testing and maintenance reports shall be provided for the owner or a designated representative. It shall be the responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having jurisdiction. Paper or electronic media shall be acceptable. This deficient practice could affect any resident, staff and visitor in the facility.</p> <p>Findings include:</p> <p>Based on review of Smoke Detector Inspection records on 07/22/15 at 3:05 p.m., with the Maintenance Supervisor</p>		<p>qualified fire alarm system provider will include a requirement that the provider conducts a bi-annual inspection and a sensitivity test of all smoke detectors at least once every two years.</p> <p>This corrective action will be monitored by: The facility fire panel detects and identifies missing or non-functioning smoke detectors which is monitored through the contracted smoke alarm provider 24 hours per day 7 days per week. Any malfunction in the fire panel / smoke detector system will be addressed immediately. Completion Date August 21, 2015</p>		

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K 0056 SS=E Bldg. 01	<p>the last smoke detection sensitivity test was done in January, 2014 and the report indicated there were 65 smoke detectors in the facility, but only 63 smoke detectors had been sensitivity tested. No other documentation was available for review to indicate the reason two smoke detectors were not tested. Based on interview on 07/22/15 at 3:08 p.m., with the Maintenance Supervisor it was acknowledged there was no written documentation or other evidence the 2 smoke detectors in the facility had been tested for sensitivity.</p> <p>3.1-19(b)</p> <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>1. Based on observation and interview, the facility failed to ensure 1 of 3 smoke</p>	K 0056	K056 The automatic sprinkler system is installed in accordance with	08/21/2015

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	<p>compartments was equipped with one type of sprinkler head, i.e., quick response sprinklers or standard sprinklers. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a compartmented space shall be changed. This deficient practice could affect 14 residents on short hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 07/22/15 at 1:15 p.m. with the Maintenance Supervisor, the short hall was equipped with one quick response sprinkler head and two standard sprinkler heads which was verified after an inspection of the sprinkler box containing each sprinkler head present in the facility. Based on interview on 07/22/15 concurrent with the observation with the Maintenance Supervisor it was acknowledged there was a mixture of one quick response and two standard response sprinkler heads in the short hall.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 3</p>		<p>NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building.</p> <p>Corrective action for residents affected:</p> <p>1. Sprinkler heads were replaced so that matching response sprinkler heads are now in each smoke compartment on the short hall.</p> <p>2. A fire sprinkler drop was installed in the electrical closet next to the employee lounge in the basement.</p> <p>Other residents having the potential to be affected and corrective actions:</p> <p>All residents have the potential to be affected by this alleged deficient practice. The contracted vendor responsible for installation of fire sprinkler heads completed a facility-wide inspection and determined that all meet this NFPA standard.</p> <p>Measures to ensure practice does not recur:</p> <p>The contracted vendor responsible for installation of fire sprinkler heads will ensure that this standard is met during future facility renovations or repairs.</p> <p>This corrective action will be monitored by:</p> <p>The contracted vendor will be responsible for routine monitoring and inspection of fire sprinkler head response and function on-going. Inspection results will be reviewed by the Executive</p>				

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K 0068 SS=F Bldg. 01	<p>electrical rooms was provided with an automatic sprinkler head to ensure sprinkler coverage in all portions of the building. This deficient practice could affect all residents on first floor as well as visitors or staff.</p> <p>Findings include:</p> <p>Based on observation on 07/22/15 at 1:35 p.m. with the Maintenance Supervisor, the electrical closet next to the employee lounge in the basement lacked sprinkler protection. Based on interview on 07/22/15 concurrent with the observation it was acknowledge by the Maintenance Supervisor, the electrical closet was not provided with sprinkler coverage.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 2 gas dryers in the laundry room were provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon</p>	K 0068	<p>Director and the regional director of facilities maintenance. Any malfunction in the fire response system will be addressed immediately. Completion Date August 21, 2015</p> <p>K068 Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. Corrective action for residents affected: Proper ventilation ducts have been installed in the laundry</p>	08/21/2015			

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	<p>monoxide which could cause physical problems for all residents on first floor as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 07/22/15 at 2:20 p.m. with the Maintenance Supervisor, the two gas fueled dryers in the laundry room in the basement were not supplied with a fresh air intake from the outside. Based on interview on 07/22/15 concurrent with the observation it was acknowledged by the Maintenance Supervisor a fresh air intake for the aforementioned gas appliances was not present.</p> <p>3.1-19(b)</p>		<p>room.</p> <p>Other residents having the potential to be affected and corrective actions:</p> <p>All residents have the potential to be affected by this alleged deficient practice. The boiler, incinerator, and heater rooms have been inspected and proper combustion and ventilation systems are in place.</p> <p>Measures to ensure practice does not recur:</p> <p>The regional director of facilities maintenance will be responsible for ensuring that proper combustion and ventilation systems are installed during future facility construction or renovation. Proper ventilation upon replacement of fuel-fired equipments will be ensured. Observation of combustion and ventilation systems for proper function has been added to the quarterly preventive maintenance checklist.</p> <p>This corrective action will be monitored by:</p> <p>The Maintenance Supervisor or designee will monitor combustion and ventilation systems for proper function quarterly. Results will be documented and reviewed by the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates.</p>		

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K 0070 SS=F Bldg. 01	<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, interview and record review, the facility failed to regulate the use of 3 of 3 portable space heaters observed in the facility. This deficient practice could affect all resident as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 07/22/15 during the tour between 11:15 a.m. to 2:30 p.m. with the Maintenance Supervisor, the following rooms had portable space heaters plugged in and ready for use:</p> <ol style="list-style-type: none"> The front nursing station. Resident room #12. The Dietary office in the kitchen. <p>Based on interview on 07/22/15 concurrent with the observations, it was acknowledged by the Maintenance Supervisor the space heaters were not allowed in the facility which was further verified by the space heater policy.</p>			K 0070	<p>Completion Date August 21, 2015</p> <p>K070 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. Corrective action for residents affected: The cited portable space heaters were removed. Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this alleged deficient practice. A facility-wide inspection was completed with no additional portable space heaters found in health care occupancy areas. Measures to ensure practice does not recur: The Admission Packet has been revised to include specific instruction to residents regarding the prohibition of portable space heaters. The Resident council and staff have been educated on the same.</p>		08/21/2015

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K 0147 SS=E Bldg. 01	<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>Based on observation and interview, the facility failed to ensure 1 of 6 ground fault interrupter (GFI) outlets observed would trip when the test button was engaged. This deficient practice could affect 8 residents in the dining adjacent to the kitchen as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 07/22/15 at 1:30 p.m. a GFI outlet located above the sink in the kitchen on the long hall would not trip when the test button was engaged.</p>	K 0147	<p>This corrective action will be monitored by: The Maintenance Supervisor or designee will complete environmental audits weekly to ensure portable space heaters are not placed in health care occupancy locations. Audit results will be reviewed by the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date 08/21/2015</p> <p>K147 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2. Corrective action for residents affected: The GFI outlet was removed. Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this alleged deficient practice. A facility-wide test of all required GFI outlets was completed and all are functioning properly. Measures to ensure practice does not recur:</p>	08/21/2015	

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	Based on interview on 07/22/15 concurrent with the observation it was acknowledged by the Maintenance Supervisor, the GFI would not trip when the test button was engaged. 3.1-19(b)		The regional director of facilities maintenance will be responsible for ensuring that functional GFI outlets are installed during future facility construction or renovation. This corrective action will be monitored by: The Maintenance Supervisor or designee will complete environmental audits monthly to ensure GFI outlets are functioning properly. Audit results will be reviewed by the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates. Completion Date August 21, 2015		