

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155586	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/08/2013
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NAME OF PROVIDER OR SUPPLIER  LUTHERAN LIFE VILLAGES	STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816
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K010000	<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: 03/07/13 and 03/08/13</p> <p>Facility Number: 000283 Provider Number: 155586 AIM Number: 100275020</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Lutheran Life Villages 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>The main building is a three story, partially sprinklered building determined to be of Type I (332) construction with a basement. The Health and Rehabilitation building is a one story sprinklered building of Type I (332) construction. The main building has a fire alarm system</p>	K010000		
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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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	<p>with smoke detection in corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The Health and Rehabilitation building has a fire alarm system with smoke detection in the corridors, areas open to the corridors and single station battery operated smoke detector in the resident rooms. The facility has a capacity of 234 and had a census of 126 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered with the exception of the garage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/14/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010018 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. Based on observation and interview, the facility failed to ensure 1 of 1 doors protecting room number 346 at the Tulip Lane nurses' station was smoke resistive. This deficient practice could affect any of the 32 residents on Tulip Lane.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Maintenance and the Assistant Director of Maintenance on 03/08/13 at 11:20 a.m., there were four pencil size holes in the corridor door to room number 346 at the Tulip Lane nurses' station. Based on an interview with the Director of Maintenance at the time of observation, the door knob had been changed to a different style.</p>	K010018	<p><b>What measures were taken for residents directly affected?</b> No residents were directly affected by this deficient practice. <b>What measures were put in place to identify other residents at risk?</b> All residents are at risk to be affected by this deficient practice. All doors were reviewed by the Life Safety Code surveyor. No additional similar areas were noted at that time. <b>What systemic change was put in place to ensure the deficient practice does not recur?</b> All penetrations in door to room number 346 at the Tulip Lane nurses station have been filled. All pertinent staff has been in-serviced on this physical plant update and the code requirements supporting it. <b>How will the corrective action be monitored?</b> The Director of</p>	04/07/2013	

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	3.1-19(b)		Maintenance and/or designee will monitor the installation or change of future door hardware and related actions that cause similar penetrations.		

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K010021 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 1 of 12 horizontal exit double smoke barrier doors in Health and Rehabilitation were held open only by a device which would allow it to close automatically upon activation of the fire alarm system. This deficient practice could affect 11 residents on the Lilac east wing.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance and the Assistant Director of Maintenance on 03/08/13 at 1:30 p.m., the south door of the double doors entering Health and Rehabilitation was held open with a magnet that did not release upon activation of the fire alarm system. This was acknowledged by the</p>	K010021	<p><b>What measures were taken for residents directly affected?</b> No residents were directly affected by this deficient practice. <b>What measures were put in place to identify other residents at risk?</b> All residents are at risk to be affected by this deficient practice. This door is used to create a smoke barrier between two common areas. <b>What systemic change was put in place to ensure the deficient practice does not recur?</b> This is door is routinely tested during monthly fire drills. It is also serviced and inspected per regulations by Koorsen Fire Protection Co. Koorsen was contacted and serviced the magnetic door release noted during this survey period. The door was tested and validated to be working properly at the time of this report. <b>How will the corrective action be</b></p>	04/07/2013			

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	Director of Maintenance at the time of observation.  3.1-19(b)		<b>monitored?</b> The Director of Maintenance and/or designee will monitor the activating of fire doors during routine testing of fire alarm system. Any hardware failures similar to those noted during the survey will be reported to the Quality Assurance committee monthly for six months.		

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K010025 SS=D	<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 the penetrations caused by the passage of wire and/or conduit through 9 of 12 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. 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 a 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 practice could affect 88 residents.</p> <p>Findings include:  Based on observations with the Director</p>	K010025	<p><b>What measures were taken for residents directly affected?</b> No residents were directly affected by this deficient practice. <b>What measures were put in place to identify other residents at risk?</b> All residents are at risk to be affected by this deficient practice. Areas noted were in adjoining corridors. These walls have been installed in their current state for 25+ years with neither incident nor code violation. <b>What systemic change was put in place to ensure the deficient practice does not recur?</b> Noted areas a. thru i. have been addressed. The expandable foam filler that was present at inspection has been removed and replaced with fire rated caulk and fire stop material in all noted areas. All pertinent staff has been in-serviced on this physical plant update and the code requirements supporting it. <b>How will the corrective action be monitored?</b> The Director of</p>	04/07/2013			

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	<p>of Maintenance and the Assistant Director of Maintenance on 03/08/13 from 11:32 a.m. to 2:42 p.m., penetrations above the lay in ceiling in the following Health and Rehabilitation smoke barrier walls were either sealed with expandable foam or left unsealed:</p> <p>a. at the smoke barrier doors entering Lilac Court west, six of eight penetration were sealed with expandable foam and two of eight penetrations were unsealed. One penetration measured one fourth inch around and the other measured six inches around.</p> <p>b. at the smoke barrier doors entering Gardenia east from the nurses' station, seven of ten penetrations were sealed with expandable foam.</p> <p>c. at the smoke barrier doors entering Gardenia west from the nurses' station, six penetrations were sealed with expandable foam and two penetrations measuring one half inch each were left unsealed.</p> <p>d. at the smoke barrier doors entering Lilac east, three of fourteen penetration were sealed with expandable foam.</p> <p>e. at the smoke barrier door in the center of Tulip Lane, ten of twelve penetration were sealed with expandable foam. A six inch by six inch hole was covered with Styrofoam. Additionally, there were gaps at the top of the smoke barrier wall where the corrugated roof decking meets the</p>		Maintenance and/or designee will monitor the installation of any new wall penetrations to insure no voids or gaps are present in the Smoke Barrier walls.		

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	<p>block wall that were unsealed.</p> <p>f. at the smoke barrier wall between Tulip Lane and the dining room, four of eight penetrations were sealed with expandable foam. There was an unsealed four inch by eight inch hole around conduit.</p> <p>g. at the smoke barrier wall entering Phrenic, the gaps between the corrugated roof decking and the block wall were stuffed with fiberglass insulation.</p> <p>h. at the smoke barrier wall between Gardenia west and Extended B, three of five penetrations were sealed with expandable foam.</p> <p>i. at the smoke barrier wall between Gardenia east and Extended A, there was an unsealed penetration measuring one inch by four inches and two penetrations were sealed with expandable foam. These were acknowledged by the Director of Maintenance and measurements were provided by the Director of Maintenance at the time of observations.</p> <p>3.1-19(b)</p>				

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K010027 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 12 sets of smoke barrier doors in Health and Rehabilitation would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. The Phrenic wing is currently closed and not currently occupied therefore this deficient practice could affect only facility staff.</p> <p>Finding include:</p> <p>Based on observation with the Director of Maintenance and the Assistant Director of Maintenance on 03/08/13 at 11:25 a.m., the smoke barrier doors entering the Phrenic wing had a one half inch gap</p>	K010027	<p><b>What measures were taken for residents directly affected?</b> No residents were directly affected by this deficient practice. <b>What measures were put in place to identify other residents at risk?</b> No residents are at risk to be affected by this deficient practice. The noted area is currently closed and unoccupied. <b>What systemic change was put in place to ensure the deficient practice does not recur?</b> The rubber astragal was replaced eliminating the gap between doors in the noted area. All pertinent staff has been in-serviced on this physical plant update and the code requirements supporting it. <b>How will the corrective action be monitored?</b> The Director of Maintenance and/or designee will perform monthly rounds to monitor for inappropriate gaps between fire doors. Any unusual findings will be reported to the Quality Assurance committee for a period of six months.</p>	04/07/2013			

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	<p>between the doors when closed. Based on an interview with the Director of Maintenance at the time of observation, the rubber astragal is torn and worn away between the doors causing the gap between the doors.</p> <p>3.1-19(b)</p>				

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K010029 SS=D	<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>Based on observation and interview, the facility failed to ensure 4 of 4 doors entering the kitchen, a hazardous area, would self close and latch into the frame. According to the Administrator, this deficient practice could affect 1 resident in the first floor dining room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator, Director of Maintenance and the Assistant Director of Maintenance on 03/07/13 at 3:07 p.m., all four corridor doors entering the kitchen lacked positive latching hardware and failed to positively latch into the door frame. Based on an interview with the Assistant Director of Maintenance at the time of observation, the doors were only equipped with dead bolts that would latch into the door frame.</p>	K010029	<p><b>What measures were taken for residents directly affected?</b> No residents were directly affected by this deficient practice. <b>What measures were put in place to identify other residents at risk?</b> All residents are at risk to be affected by this deficient practice. The kitchen doors have been installed in their current state for 10+ years with neither incident nor code violation. <b>What systemic change was put in place to ensure the deficient practice does not recur?</b> One (1) set of Dorma Model 8400LBdoor hardware is being ordered for each set of doors entering the kitchen. Installation will occur as soon as possible, subject to parts and service availability from the third-party contractor. This hardware will latch into the casing and provide a panic bar exit device configuration. All pertinent staff has been in-serviced on this</p>	04/07/2013			

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	3.1-19(b)		physical plant update and the code requirements supporting it. <b>How will the corrective action be monitored?</b> The Director of Maintenance and/or designee will monitor the installation of both double doors includes the installation of properly latching hardware.		

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K010048 SS=B	<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 Based on record review and interview, the facility failed to provide a written plan which included the preparation of a floor for evacuation in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice affects all 27 residents on the second and third floors of the main building.</p> <p>Findings include:</p> <p>Based on a record review with the Assistant Director of Maintenance on 03/07/13 at 2:10 p.m., the "Emergency Preparedness Policies" did not address preparation of the second and third floors in the main building for evacuation. This was confirmed by the Assistant Director</p>	K010048	<p><b>What measures were taken for residents directly affected?</b> No residents were directly affected by this deficient practice. <b>What measures were put in place to identify other residents at risk?</b> All residents living in the noted areas were at risk to be affected by this deficient practice. <b>What systemic change was put in place to ensure the deficient practice does not recur?</b> The policies and procedures for "Fire" and "Evacuation" were reviewed and revised to include language addressing vertical evacuation. All pertinent staff has been in-serviced on these "updated policies and the code requirements supporting them. <b>How will the corrective action be monitored?</b> All pertinent staff will be in-serviced on the above noted policies and procedures on an annual basis.</p>	04/07/2013			

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	of Maintenance at the time of record review.  3.1-19(b)			

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NAME OF PROVIDER OR SUPPLIER  LUTHERAN LIFE VILLAGES				STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816			
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K010051 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 4 of 6 manual fire alarm boxes on the second and third floors of the main building were mounted at the proper height. NFPA 72, National Fire Alarm Code, 2-8.1 states the operable part of each manual fire alarm box shall be not less the forty two inches and not more than fifty four inches from the floor level. This deficient practice affects all 27 residents on the second and third floors of the main building.</p> <p>Findings include:  Based on observations with the Director</p>	K010051	<p><b>What measures were taken for residents directly affected?</b> No residents were directly affected by this deficient practice. <b>What measures were put in place to identify other residents at risk?</b> 27 residents are at risk to be affected by this deficient practice. <b>What systemic change was put in place to ensure the deficient practice does not recur?</b> Three (3) second floor and one (1) third floor fire alarms were lowered from sixty inches to 54" to comply. All pertinent staff has been in-serviced on this physical plant update and the code requirements supporting it. <b>How will the corrective action be monitored?</b> The Director of</p>	04/07/2013			

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	of Maintenance and the Assistant Director of Maintenance 03/08/13 from 12:50 p.m. to 1:00 p.m., all three manual fire alarm boxes on the second floor of the main building measured sixty inches from the floor level to the bottom of the box. The third floor center manual fire alarm box measured sixty inches from the floor level to the bottom of the box. Measurements were provided by the Director of Maintenance at the time of observations.		Maintenance and/or designee will monitor the relocation of manual fire alarm boxes on second and third floors to correct height for compliance.		

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K010056 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 ensure complete sprinkler coverage was provided for 1 of 1 Lilac east phone equipment closets and 2 of 2 elevator equipment rooms to provide complete sprinkler coverage for all portions of the building. This deficient practice could affect residents in the game room with enough chairs to seat 45 residents.</p> <p>Findings include:</p> <p>a. Based on observation with the Director of Maintenance and the Assistant Director of Maintenance on 03/07/13 at 2:20 p.m., the service elevator equipment room in the basement lacked sprinkler coverage. The room was constructed of concrete and block with a nonrated steel door that</p>	K010056	<p><b>What measures were taken for residents directly affected?</b> No residents were directly affected by this deficient practice. <b>What measures were put in place to identify other residents at risk?</b> All residents were at risk to be affected by this deficient practice. <b>What systemic change was put in place to ensure the deficient practice does not recur?</b> a. Professional installation of fire suppression systems in the noted elevator areas is scheduled to occur at the earliest convenience of the vendor, and is also sensitive to parts availability. b. The doors were removed from phone equipment closet allowing sprinkler access on Lilac Wing. All pertinent staff has been in-serviced on this physical plant update and the code requirements supporting it. <b>How will the corrective action be</b></p>	04/07/2013			

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	<p>lacked a self closing device. Based on observation with the Director of Maintenance and the Assistant Director of Maintenance on 03/08/13 at 12:55 p.m., the passenger elevator equipment room in the game room lacked sprinkler coverage. The room was constructed of concrete and block with a nonrated steel door that lacked a self closing device.</p> <p>b. Based on observation with the Director of Maintenance and the Assistant Director of Maintenance on 03/08/13 at 11:15 a.m., the closet housing the phone equipment on Lilac east wing lacked sprinkler coverage.</p> <p>These were acknowledged by the Director of Maintenance at the time of observations.</p> <p>3.1-19(b)</p>		<p><b>monitored?</b> The Director of Maintenance and/or designee will monitor the renovation of future areas to ensure proper fire suppression systems are installed.</p>		

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K010067 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure an undetermined number of dampers in the ventilation system at the corridor walls in Tulip Lane and possibly Phrenic were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice could affect any number of the 32 residents in Tulip Lane. Phrenic is currently closed and unoccupied.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 03/08/13 at 12:15 p.m.,</p>	K010067	<p><b>What measures were taken for residents directly affected?</b> No residents were directly affected by this deficient practice. <b>What measures were put in place to identify other residents at risk?</b> Thirty-two (32) residents of Tulip Lane were at risk to be affected by this deficient practice. <b>What systemic change was put in place to ensure the deficient practice does not recur?</b> All fire dampers will be inspected and tested a minimum of every four years per the related code requirement. The noted areas will be inspected and tested by the date of intended compliance. All pertinent staff has been in-serviced on this physical plant update and the code requirements supporting it. <b>How will the corrective action be monitored?</b> The Director of Maintenance and/or designee will monitor the inspection and testing of fire dampers.</p>	04/07/2013			

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	<p>there was a fire/smoke damper in the ventilation duct at the corridor wall entering resident room 325 in Tulip Lane. Based on an interview with the Assistant Director of Maintenance during the record review process on 03/07/13 at 1:25 p.m., he was not aware the dampers needed to be inspected.</p> <p>3.1-19(b)</p>			

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K010075 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area for 1 of 8 Health &amp; Rehabilitation corridors. This deficient practice could affect any of the 32 residents on Tulip Lane.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance and the Assistant Director of Maintenance on 03/08/13 from 11:00 a.m. to 12:20 p.m., a dual container cart with a 30 gallon plastic bag of soiled linen approximately two thirds full, and a 30 gallon plastic bag of trash was unattended and stored in the Tulip Lane from 11:00 a.m. to 12:20 p.m. Based on an interview with the Director of Maintenance at the time of observation, he acknowledged both containers of the</p>	K010075	<p><b>What measures were taken for residents directly affected?</b> No residents were directly affected by this deficient practice. <b>What measures were put in place to identify other residents at risk?</b> Thirty-two (32) residents were at risk to be affected by this deficient practice. <b>What systemic change was put in place to ensure the deficient practice does not recur?</b> Soiled linen or trash receptacles greater than 32 gallon capacity shall be located in a room protected as a hazardous area when not attended. All pertinent staff has been in-serviced on this update and the code requirements to maintain compliance. <b>How will the corrective action be monitored?</b> The Director of Maintenance and/or designee will monitor the storage of soiled linen or trash receptacles greater than 32 gallon capacity. Areas of persistent noncompliance will be reported to the Quality Assurance Committee monthly for six</p>	04/07/2013			

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	cart will hold a thirty gallon trash bag.  3.1-19(b)		months.	

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K010104 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. Based on observation and interview, the facility fail to ensure the duct penetrations through 1 of 12 Health and Rehabilitation smoke barrier walls was provided with a smoke damper. LSC 101 section 8.3.5.1 states an approved damper designed to resist the passage of smoke shall be provided for each air transfer opening or duct penetration of a required smoke barrier. This deficient practice affects 39 residents on Lilac west and Tulip Lane.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance and the Assistant Director of Maintenance on 03/08/13 at 2:24 p.m., the ventilation duct penetrating the smoke barrier wall between Lilac west and Tulip Lane lacked a smoke damper. At the time of observation, this was confirmed by the Director of Maintenance.</p> <p>3.1-19(b)</p>	K010104	<p><b>What measures were taken for residents directly affected?</b> No residents were directly affected by this deficient practice. <b>What measures were put in place to identify other residents at risk?</b> No residents are at risk to be affected by this deficient practice. <b>What systemic change was put in place to ensure the deficient practice does not recur?</b> No changes were needed, as it was confirmed that all the ducts that penetrate smoke barrier walls have fire/smoke dampers. The noted area does not have any ventilation penetration. This discrepancy was discussed via phone with Supervisor Dennis Austill, ISDH, on 3/26/2013. <b>How will the corrective action be monitored?</b> The Director of Maintenance and/or designee will monitor the installation of any duct work installed to ensure they have the required fire/smoke dampers.</p>	04/07/2013			

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation, and interview; the facility failed to ensure there was documentation for the testing of 100 of 100 resident room smoke detectors. LSC 4.6.1.2 states any requirements that are essential for the safety of building occupants and that are not specifically provided for by this code shall be determined by the authority having jurisdiction. LSC 4.6.12.3 states equipment requiring periodic testing or operation to ensure its maintenance shall be tested or operated as specified elsewhere in this code or as directed by the authority having jurisdiction. This deficient practice could affect all 99 residents in Health and Rehabilitation.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance and the Assistant Director of Maintenance on 03/08/13 from 10:15 a.m. to 2:40 p.m., battery operated smoke detectors were observed in the resident rooms in Health and Rehabilitation.</p> <p>Based on record review with the Assistant Director of Maintenance on 03/07/12 at 12:42 p.m., there was no documentation to show the battery operated smoke detectors on Tulip Lane and Phrenic were</p>	K010130	<p><b>What measures were taken for residents directly affected?</b> No residents were directly affected by this deficient practice. <b>What measures were put in place to identify other residents at risk?</b> Ninety-nine residents are at risk to be affected by this deficient practice. <b>What systemic change was put in place to ensure the deficient practice does not recur?</b> Monthly smoke detector tests have been scheduled via the TELS monitoring system to ensure monthly inspection. All related smoke detectors were inspected and tested during this compliance period. All pertinent staff has been in-serviced on this physical plant update and the code requirements supporting it. <b>How will the corrective action be monitored?</b> The Director of Maintenance and/or designee will monitor the required smoke detector inspection on a monthly basis. This monitoring will be reported to the Quality Assurance Committee for a period of six months.</p>	04/07/2013	

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	<p>tested in the month of December 2012. Additionally, there was no documentation of a monthly test for all one hundred smoke detectors for the months of July, October and November of 2012. Based on an interview with the Assistant Director of Maintenance on 03/07/13 at 1:30 p.m., no other documentation was available for review to show the battery operated smoke detectors received a monthly test for the months previously indicated above.</p> <p>3-1.19(b)</p>			

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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure the load testing for the past 12 of 12 months indicated a load test was conducted under operating temperature conditions, minimum exhaust gas temperatures or not less than 30 percent of the nameplate rating for the diesel powered emergency generator set. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating temperature conditions, maintains the minimum exhaust gas temperatures or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, Section 3-4.1.1.8 states the generator set shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection,</p>	K010144	<p><b>What measures were taken for residents directly affected?</b> No residents were directly affected by this deficient practice. <b>What measures were put in place to identify other residents at risk?</b> All residents are at risk to be affected by this deficient practice. Facility records indicate that all required generator tests were completed per regulation during the survey period. It is only the facility form utilized that did not indicate the parameters at which the tests were conducted. <b>What systemic change was put in place to ensure the deficient practice does not recur?</b> The protocol and related documentation for testing the generators was amended to include the following steps: a. Perform and record test for 30 minute at 30% load, documenting that the generators were exercised under operating conditions, maintaining the minimum exhaust gas temperatures for not less than thirty percent of the EPS nameplate rating. Perform monthly. b. Perform and record the test for the main building's generator, documenting it was run for twenty minutes monthly. c. Include transfer time in</p>	04/07/2013			

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	<p>performance, exercising period and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review of the "Monthly Generator Checklist" with the Assistant Director of Maintenance on 03/07/12 at 1:00 p.m., the generator test logs indicated the following</p> <p>a. a monthly load test for the past twelve months for both generators but the log did not indicate if the diesel generators were exercised under operating conditions, maintaining the minimum exhaust gas temperatures or not less than thirty percent of the EPS nameplate rating at least monthly, for a minimum of thirty minutes.</p> <p>b. the main building's generator was run for twenty minutes for the month of February 2013 and August, October and November 2012 and June.</p> <p>c. the generator log for both generators doesn't include transfer time for the months of November, October, August, July, June and May of 2012</p> <p>This was acknowledged by the Assistant Director of Maintenance at the time of record review.</p>		<p>generator log monthly. All pertinent staff has been in-serviced on this physical plant update and the code requirements supporting it. <b>How will the corrective action be monitored?</b> The Director of Maintenance and/or designee will monitor testing and documentation of generators.</p>				

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K010154 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to protect 126 of 126 residents by providing a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned and</p>	K010154	<p><b>What measures were taken for residents directly affected?</b> No residents were directly affected by this deficient practice. <b>What measures were put in place to identify other residents at risk?</b> All residents are at risk to be affected by this deficient practice. <b>What systemic change was put in place to ensure the deficient practice does not recur?</b> The policy and procedure for fire watch was reviewed and revised to include language addressing the training of designated persons to perform the duties required when conducting a fire watch. All pertinent staff has been in-serviced on this update and the code requirements supporting it. <b>How will the corrective action be monitored?</b> The Director of Maintenance and/or designee will monitor the documentation and training of designated personnel to perform the duties required when conducting a fire watch.</p>	04/07/2013			

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	<p>lastly 11-7 requires notification of everyone again when the system is restored. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Policy and Procedure: Fire Watch" policy with the Assistant Director of Maintenance on 03/07/13 at 2:00 p.m., the facility did have a written policy and procedure for an impaired sprinkler system available for review, but it did not include the designated person(s) shall be trained in the duties or responsibilities of conducting the fire watch. Based on an interview with the Assistant Director of Maintenance at the time of record review, he acknowledged the fire watch policy lacked documentation stating the person(s) conducting the fire watch shall be properly trained in the duties required when conducting a fire watch.</p> <p>3.1-19(b)</p>				

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K010155 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 126 of 126 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice affect all occupants.</p>	K010155	<p><b>What measures were taken for residents directly affected?</b> No residents were directly affected by this deficient practice. <b>What measures were put in place to identify other residents at risk?</b> All residents are at risk to be affected by this deficient practice. <b>What systemic change was put in place to ensure the deficient practice does not recur?</b> The policy and procedure for fire watch was reviewed and revised to include language addressing the training of designated persons to perform the duties required when conducting a fire watch. All pertinent staff has been in-serviced on this update and the code requirements supporting it. <b>How will the corrective action be monitored?</b> The Director of Maintenance and/or designee will monitor the documentation and training of designated personnel to perform the duties required when conducting a fire watch.</p>	04/07/2013			

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	<p>Findings include:</p> <p>Based on record review of the "Policy and Procedure: Fire Watch" policy with the Assistant Director of Maintenance on 03/07/13 at 2:00 p.m., the facility did have a written policy and procedure for an impaired fire alarm system available for review, but it did not include the designated person(s) shall be trained in the duties or responsibilities of conducting the fire watch. Based on an interview with the Assistant Director of Maintenance at the time of record review, he acknowledged the fire watch policy lacked documentation stating the person(s) conducting the fire watch shall be properly trained in the duties required when conducting a fire watch.</p> <p>3.1-19(b)</p>				

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K019999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(a) A health facility licensed under 16-28 and this rule states the facility must be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to ensure the electrical equipment in 2 of 2 elevator equipment rooms was properly maintained to protect personnel. This deficient practice was not in a resident care area but could affect maintenance staff.</p> <p>Findings include:</p> <p>a. Based on observation with the Director of Maintenance and the Assistant Director of Maintenance on 03/07/13 at 2:20 p.m., the electrical elevator equipment in the main building basement elevator equipment room lacked an enclosure and/or safety guards.</p> <p>b. Based on observation with the Director of Maintenance and the Assistant Director</p>	K019999	<p><b>What measures were taken for residents directly affected?</b> No residents were directly affected by this deficient practice. <b>What measures were put in place to identify other residents at risk?</b> No residents are at risk to be affected by this deficient practice. The noted area is an elevator mechanical room accessible only to authorized personnel. <b>What systemic change was put in place to ensure the deficient practice does not recur?</b> Professional installation of safety guards protecting the electrical components of the elevator mechanics is scheduled to occur at the earliest convenience of the vendors involved, and is also sensitive to parts availability. All pertinent staff has been in-serviced on this update and the code requirements supporting it. <b>How will the corrective action be monitored?</b> The Director of Maintenance and/or designee will monitor the documentation and training of designated personnel to perform the duties required when conducting a fire watch.</p>	04/07/2013	

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	<p>of Maintenance on 03/08/13 at 12:55 p.m., the back side of the electrical elevator equipment in the elevator equipment room located in the game room of the Health and Rehabilitation building lacked an enclosure or a safety guard.</p> <p>Based on an interview with the Assistant Director of Maintenance at the time of observation, this equipment has never been enclosed or had safety guards in place.</p> <p>3.1-19(a)</p>			