

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2013
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NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516
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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: 05/07/13</p> <p>Facility Number: 003075 Provider Number: 155695 AIM Number: 200364160</p> <p>Surveyors: Dennis Austill, Life Safety Code Supervisor; Robert Sutton, Life Safety Code Specialist Trainee</p> <p>At this Life Safety Code survey, Riverside Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a partial basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors.</p>	K010000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after June 6, 2013.	

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>The facility has 22 resident rooms with battery operated smoke detectors and 26 resident rooms with hard wired smoke detectors. The facility has a capacity of 97 and had a census of 76 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached shed providing storage services which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/09/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010017 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 areas were separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or meet an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by automatic sprinklers, or the furnishings and furniture, in combination with all other combustibles within the area, are of such minimum quantity and</p>	K010017	<p>K017 – Corridors Are Separated From Use Areas by Wall Constructed With At Least ½ Hour Fire Resistance Rating. It is the practice of this provider to assure resident safety by providing properly placed electrically supervised automatic smoke detection system. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: H&G Services (electrical services provider) has installed an electrically supervised automatic smoke detector in the scale room. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</p>	06/06/2013			

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	<p>arrangement that a fully fully developed fire is unlikely to occur and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect at least six residents, staff or visitors in the vicinity of the scale room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility at 11:05 a.m. on 05/07/13, the scale room had two openings without doors in the wall separating the room from the corridor on the east 500 hall. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because the scale room was not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of observation, the Maintenance Director acknowledged the scale room was not protected by an electrically supervised smoke detection system.</p> <p>3.1-19(b)</p>		<p>action(s) will be taken: All residents have the potential to be affected by this finding.</p> <p>H&G Services (electrical services provider) has installed an electrically supervised automatic smoke detector in the scale room. Maintenance Director inspected all rooms throughout building to ensure automatic smoke detector was available. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director or Designee to monitor smoke detectors for proper placement during routine daily/weekly/or monthly preventative maintenance rounds. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Maintenance Director or Designee to report status of smoke detectors rounds monthly to CQI Committee. By what date the systemic changes will be completed: Compliance Date: 6/06/13.</p>		

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K010018 SS=F	<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>1. Based on observation and interview, the facility failed to ensure the doors to 3 of 3 clean linen rooms were provided with positive latching hardware. This deficient practice had the potential to affect all 76 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility from 9:15 a.m. to 11:45 a.m. on 05/07/13, the double doors to the 400 hall and 200 hall clean linen rooms had magnetic catches at the top of the doors and were provided with a slide bolt to keep the doors closed. The 100 hall clean linen room doors latched into each other and was provided with a slide bolt to keep</p>	K010018	<p>K018 – Doors Are Provided With A Means Suitable For Keeping Doors Closed. It is the practice of this provider to assure all residents are safe by utilizing properly closing doors. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: <i>New double doors for the 400 hall and 200 hall clean linen rooms (closets), and 100 hall clean linen room (closet) have been ordered and will be installed with appropriate latching devices upon receipt. Room 401 door catch plate was replaced. Therapy room kick-down door stop was removed.</i> How other residents having the</p>	06/06/2013			

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	<p>the doors closed. Based on interview at the time of observation, the Maintenance Director acknowledged the clean linen room doors were not provided with positive latching hardware.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 48 resident room doors prevented the passage of smoke. This deficient practice could affect at least 10 resident in the 400 hall corridor as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility at 9:55 a.m. on 05/07/13, resident room 401 had a missing door catch plate which allowed a gap greater than a 1/2 inch between the face of the door and the door stop of the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged room 401 had a missing catch plate and the gap exceeded 1/2 inch between the door and frame.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview,</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>All residents have the potential to be affected by this finding.</p> <p><i>New double doors for the 400 hall and 200 hall clean linen rooms (closets), and 100 hall clean linen room (closet) have been ordered and will be installed with appropriate latching devices upon receipt.</i></p> <p><i>Room 401 door catch plate was replaced.</i></p> <p><i>Therapy room kick-down door stop was removed.</i></p> <p><i>All doors were inspected by Maintenance Director to ensure positive latching hardware was available, door catch plates present.</i></p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Maintenance Director/Designee to monitor proper closing of doors 5 days a week for 4 weeks, and then during routine daily/weekly/or monthly maintenance rounds thereafter.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p>		

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	<p>the facility failed to ensure 1 of 1 therapy room doors did not have an impediment to the closing of the door. This deficient practice could affect at least 10 residents on the 300 hall as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility at 10:05 a.m. on 05/07/13, the door to the therapy room was blocked open by a kick-down door stop attached to the bottom of door. Based on interview at the time of observation, the Maintenance Director acknowledged the therapy room was held open by a kick-down door stop.</p> <p>3.1-19(b)</p>		<p>Maintenance Director/Designee to report findings of rounds monthly to CQI Committee for review and any necessary corrective action.</p> <p>By what date the systemic changes will be completed: Compliance date = 6/06/13</p>		

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K010025 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 the passage of cable through 4 of 8 smoke barriers was protected to maintain the smoke resistance of each 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 that 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 at least 38 residents as well as staff and visitors if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of</p>	K010025	<p>K025– Smoke Barriers Are Constructed to Provide At Least ½ Hour Fire Resistance Rating.</p> <p>It is the practice of this provider to assure the safety of all residents by providing appropriate fire resistant smoke barriers.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Attic drywall fire-rated smoke barrier material near the Social Services Office has been installed.</p> <p>Attic concrete fire-rated smoke barrier material near 100 hall mechanical room has been installed.</p> <p>Attic concrete fire-rated smoke barrier material near beauty salon has been installed.</p> <p>Expandable foam in 100 Electrical room was removed</p>	06/06/2013			

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	<p>the facility from 9:15 a.m. to 11:45 a.m. on 05/07/13, there were exposed penetrations through the smoke barriers in the attic at the following locations that were not firestopped:</p> <p>a. The attic drywall smoke barrier near the Social Services office had a three inch annular space around a sprinkler pipe penetration that was not sealed.</p> <p>b. The attic concrete smoke barrier near the 100 hall mechanical room had a three inch annular space around a square metallic duct that had blue cables running through the opening that was not sealed.</p> <p>c. The attic concrete smoke barrier near the beauty salon had a three inch annular space around a square metallic duct that had blue cables running through the opening that was not sealed.</p> <p>d. Additionally, two ceiling penetrations by conduit and cable in the 100 Electrical room were sealed with expandable foam. Based on interview during the times of observation, the Maintenance Director acknowledged the unprotected openings had been created by the facility running DSL cables for the Internet through the smoke barriers and the expanding foam had been installed before he came to the facility.</p> <p>3.1-19(b)</p>		<p>and proper fire-rated smoke barrier installed.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>All residents have the potential to be affected by this practice. All areas of deficiency have been corrected utilizing proper smoke barrier materials. Attic was inspected by maintenance to ensure all other potential areas were protected by smoke barrier material.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Maintenance Director/Designee to monitor areas requiring smoke barrier material 5 days a week for four weeks and during routine daily/weekly/or monthly maintenance rounds thereafter to assure proper barrier is in place.</p> <p>Maintenance Director will inspect the area when new wiring, or pipe, is installed to ensure proper placement of smoke barrier material.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</p>				

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			<p>program will be put into place: Maintenance Director/Designee to submit report of findings to monthly CQI Committee for review and any necessary correction.</p> <p>By what date the systemic changes will be completed: Compliance Date: 6/06/13.</p>	

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K010027 SS=E	<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 3 of 8 sets of smoke barrier doors 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. This deficient practice could affect at least 30 of 76 residents as well as staff and visitors.</p> <p>Finding include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility from 9:15 a.m. to 11:45 a.m. on 05/07/13, the coordinating device on the 100 and 200 hall smoke barrier doors did not operate properly preventing the doors from closing completely leaving a</p>	K010027	<p>K027 – Door Openings In Smoke Barriers Have At Least A 20-Minute Fire Protection Rating It is the intent of this provider to assure all residents safety by providing appropriate smoke barrier doors to restrict the movement of smoke for at least 20 minutes. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The coordinating device on the 100 and 200 hall smoke barrier doors has been repaired. The ½” hole in the top of the doors in basement has been filled.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to</p>	06/06/2013			

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	<p>six inch gap. Additionally, the set of smoke barrier doors in the basement near the elevator had an 1/2 inch hole in the top of one of the doors created by the removal of a magnetic plate that had been installed on the door. Based on interview, these observations were acknowledged by the Maintenance Director during the tour.</p> <p>3.1-19(b)</p>		<p>be affected by this practice. The coordinating device on the 100 and 200 hall smoke barrier doors has been repaired. The 1/2" hole in the top of the doors in basement has been filled.</p> <p>Maintenance Director inspected all smoke barrier doors to ensure all closed properly.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director/Designee to monitor smoke barrier doors for proper operation 5 days per week for 4 weeks and during daily/weekly/or monthly routine maintenance rounds thereafter. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Maintenance Director/Designee to submit report of monitoring to monthly CQI Committee for review and any necessary corrective action. By what date the systemic changes will be completed: Compliance date = 6/06/13</p>		

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K010029 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>Based on observation and interview, the facility failed to ensure 2 of 8 doors serving hazardous areas closed and latched to prevent the passage of smoke. This deficient practice could affect at least 10 residents, visitors and staff in and near the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility at 9:45 a.m. on 05/07/13, one leaf of the main kitchen double doors dragged against the ceramic floor and the nearby 400 hall mechanical room door was provided with a door closer but did not latch. Based on interview during the time of observation, the Maintenance Director acknowledged the doors to these rooms needed to be manually pulled shut to latch the doors.</p>	K010029	<p>K029 – One Hour Fire Rated Construction, Or An Approved Automatic Fire Extinguishing System Protects Hazardous Areas.</p> <p>It is the practice of this provider to assure the safety of all residents by providing appropriate one hour fire rated construction, or an approved automatic fire extinguisher system which protects hazardous areas.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Kitchen door has been repaired for proper closing.</p> <p>400 Mechanical Room door closer was adjusted for proper latching.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</p>	06/06/2013			

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	3.1-19(b)		<p>action(s) will be taken: All residents have the potential to be affected by this practice. Kitchen door has been repaired for proper closing. 400 Mechanical Room door closer was adjusted for proper latching. Maintenance Director observed all doors serving hazardous areas throughout facility to ensure doors closed and latched properly. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director/Designee to monitor kitchen door, mechanical room door, and all other doors serving hazardous areas during routine daily/weekly/or monthly maintenance rounds to assure proper closing.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Maintenance Director/Designee to submit report of monitoring findings to monthly CQI Committee for review and any necessary corrective action.</p> <p>By what date the systemic changes will be completed: Compliance date = 6/06/13</p>		

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K010034 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 stairway enclosure doors were in accordance with 7.2. LSC Section 7.2.1.5.4 requires a latch or other fastening device to be provided. This deficient practice affects at least 10 residents on the 300 hall including staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility at 9:45 a.m. on 05/07/13, the latch on the main floor northeast stairwell exit door was not functioning and this door was provided with an electromagnetic device that held the door closed when energized. It was acknowledged by the Maintenance Director that when the facility loses power or the fire alarm is activated, the magnet will release and the the stairwell door would not be latched.</p> <p>3.1-19(b)</p>	K010034	<p>K034-Stairways and Smoke proof Towers Used As Exits Are In Accordance With Safety Codes</p> <p>It is the practice of this provider to assure the safety of all residents and staff by providing properly operating stairway enclosure doors.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: An appropriate latching device has been installed to this stairway door.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this practice. An appropriate latching device has been installed to this stairway door.</p> <p>All doors were checked by Maintenance Director to ensure all applicable doors have appropriate latching device.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p>	06/06/2013			

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			<p>Maintenance Director/Designee to monitor stairway door for proper closure 5 days per week for 4 weeks and during routine daily/weekly/or monthly maintenance rounds thereafter. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Maintenance Director/Designee to submit report of rounds to monthly CQI Committee for review and any necessary corrections.</p> <p>By what date the systemic changes will be completed: Compliance date = 6/06/13</p>	

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K010046 SS=E	<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.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 20 emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect at least 10 residents in the facility including staff and visitors if the facility were required to evacuate in an emergency during a loss of normal power.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility from 9:15 a.m. to 11:45 a.m. on 05/07/13, the exterior battery operated emergency light outside the dietary exit and the interior battery operated emergency light in the south cottage unit</p>	K010046	<p>K046 – Emergency Lighting Of At Least 1 ½ Hour Duration Is Provided</p> <p>It is the intent of this facility to provide a safe, functional environment to assure the safety of all residents, staff, and visitors. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The exterior emergency light outside the dietary exit and the interior emergency light in the south Cottage unit have been repaired.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>All residents have the potential to be affected by this practice. The exterior battery operated emergency light outside the dietary exit and the interior battery operated emergency light in the south Cottage unit have been repaired.</p> <p>All emergency lights were checked by Maintenance Director to ensure all were functioning properly.</p> <p>What measures will be put into place or what systemic</p>	06/06/2013			

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	at the stairwell did not function when tested. Based on interview during the tour, the Maintenance Director acknowledged the battery operated emergency lights outside the dietary exit and south cottage unit stairwell did not function. 3.1-19(b)		changes will be made to ensure that the deficient practice does not recur: Maintenance Director/Designee to monitor emergency lighting systems for proper operation during routine daily/weekly/monthly maintenance rounds. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Maintenance Director/Designee to report findings of monitoring to monthly CQI Committee for review and any necessary corrective action. By what date the systemic changes will be completed: Completion date = 6/06/13		

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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 1 of 2 smoke detectors in the Activity/Lounge and connected to the fire alarm system were properly separated from an air supply. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect at least 10 to 15 residents using the Activity/Lounge area as well as staff and visitors.</p> <p>Findings include:</p>	K010051	<p>K051 – Fire Alarm System to Be Provided for Effective Warning of Fire In Any Part Of Building It is the practice of this provider to assure the safety of all residents by providing an effective fire alarm system to effectively warn of fire in any part of the building. <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</i> <i>The smoke alarm in the activity room has been moved from close area to air supply vent to appropriate footage.</i> <i>How other residents having the potential to be affected by the same deficient practice will be</i></p>	06/06/2013			

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	<p>Based on observation with the Maintenance Director during the tour of the facility at 9:30 a.m. on 05/07/13, one of the two smoke detectors located in the Activity/Lounge was one foot from an air supply vent. Based on interview at the time of observation, the Maintenance Director acknowledged the distance between the vent and agreed the air flow could interfere with smoke detector function.</p> <p>3.1-19(b)</p>		<p>identified and what corrective action(s) will be taken: All residents are at risk to be affected by this finding All smoke detectors were checked by Maintenance Director to ensure proper placement from air supply vent. The smoke alarm in the activity room has been moved from close area to air supply vent to appropriate footage. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director or Designee to monitor smoke alarms for correct placement during routine daily/weekly, or monthly preventative maintenance rounds. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Maintenance/Designee to submit report of findings of rounds to monthly CQI Committee for review and any necessary corrective action. By what date the systemic changes will be completed: Compliance Date: 6/06/13</p>		

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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 1 of 1 sprinkler systems was installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, NFPA 13, Section 5-1.1 states the requirements for spacing, location, and position of sprinklers shall be based on the following principles: (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. Section 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. Section 5-3.1.1 states sprinklers shall be installed in accordance with their listing. This deficient practice could affect 38 of</p>	K010056	<p>K056 – Appropriate Same Sprinkler Heads To Be Provided It is the practice of this provider to assure the safety of all residents, staff, and visitors, by providing the appropriate type of sprinkler head in each area. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The company PIPE (sprinkler system provider) has been contracted to replace any inappropriate sprinkler head and install correct sprinkler heads in all affected areas. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p>	06/06/2013			

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	<p>76 residents within the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility from 12:45 p.m. to 2:45 p.m. on 05/07/13, the following was noted:</p> <p>a. The basement laundry room had six sprinklers. Four sprinklers in the clean side with the dryers had red bulb, ordinary rated sprinklers and two green bulb, intermediate sprinklers in the soiled side of the laundry.</p> <p>b. There was a mix of quick response and standard response sprinklers in the same room or corridor in resident room 116, the east 500 hall, the basement housekeeping/storage room, basement housekeeping managers office, basement central supply, basement housekeeping/maintenance room and basement dietary storage room. Based on interview at the time of observation, the Maintenance Director acknowledged the mix of sprinkler types and ratings within the facility.</p> <p>3.1-19(b)</p>		<p>All residents have the potential to be affected by this finding.</p> <p>The company PIPE (sprinkler system provider) has been contracted to replace any inappropriate sprinkler head and install correct sprinkler heads in all affected areas.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>After completion of installation Maintenance Director/Designee to review for complete appropriateness of sprinkler heads.</p> <p>Maintenance Director/Designee to monitor sprinkler heads during routine daily/weekly/or monthly preventative maintenance rounds and sprinkler system inspections.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Maintenance Director/Designee to submit report of rounds findings to monthly CQI Committee for review and any necessary corrective action.</p> <p>By what date the systemic changes will be completed:</p> <p>Compliance Date: 6/06/13</p>		

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K010062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure the spray pattern of sprinkler heads was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice does not directly affect residents since this area is accessible to only staff members.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility from 12:45 p.m. to 2:45 p.m. on 05/07/13, the following was noted:</p> <p>a. A side wall sprinkler head above the window in resident room 101 pointed</p>	K010062	<p>K062- Spray Pattern of Fire Sprinkler Head To Be Unobstructed</p> <p>It is the practice of this provider to assure the safety of all residents, staff, and visitors by having appropriate clearance and positioning of fire sprinkler heads. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>PIPE (fire sprinkling system provider) adjusted affected sprinkler head in resident room 101 for appropriate clearance and positioning.</p> <p>Cardboard box placed in front of side wall sprinkler in basement central supply has been removed.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>All residents have the potential to be affected by this finding.</p> <p>PIPE (fire sprinkling system provider) adjusted affected sprinkler head in resident room 101 for appropriate clearance and positioning.</p>	06/06/2013			

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	<p>directly towards the ceiling.</p> <p>b. A cardboard box was placed directly in front of a side wall sprinkler above the window in the basement central supply room.</p> <p>Based on interview during the time of observation it was acknowledged by the Maintenance Director, the spray pattern of the sprinkler heads would not provide adequate coverage of the rooms.</p> <p>3.1-19(b)</p>		<p>Cardboard box placed in front of side wall sprinkler in basement central supply has been removed.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director or Designee to monitor placement and appropriate position of sprinkler heads during routine daily/weekly/or monthly preventative maintenance rounds, as well as monitoring supply room storage for appropriate clearance of sprinkler head.</p> <p>Central Supply Clerk to monitor supply room for appropriate placement of storage to assure clearance of sprinkler heads.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Maintenance Director or Designee to submit report of rounds findings to monthly CQI Committee for review and any necessary corrective action.</p> <p>By what date the systemic changes will be completed: Compliance date = 6/06/13</p>		

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K010064 SS=A	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 15 portable fire extinguishers was in accordance with NFPA 10, the Standard for Portable Fire Extinguishers. NFPA 10, 1-6.7 requires fire extinguishers shall be securely installed on the hanger or in the bracket supplied or placed in cabinets or wall recesses. This deficient practice would not directly affect residents but could affect staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility at 11:05 a.m. on 05/07/13, a portable fire extinguisher located in the laundry was placed on the folding counter space with no set location. Based on interview at the time of observation, the Maintenance Director acknowledged the portable fire extinguisher in the laundry had no set location.</p> <p>3.1-19(b)</p>	K010064	<p>K064 – Portable Fire Extinguishers Are Provided in All Health Care Occupancies in Accordance with NFPA 10</p> <p>It is the practice of this provider to assure the safety of all residents by providing appropriate placement of fire extinguishers. <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</i></p> <p><i>The fire extinguisher in the laundry room has been hung properly in a set location. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</i></p> <p>All residents are at risk to be affected by this finding. Fire extinguisher in laundry has been hung properly in set location. Maintenance Director inspected all fire extinguishers throughout building to ensure they were securely in proper placement.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</i> <i>Laundry staff to be educated by the Laundry Supervisor on</i></p>	06/06/2013

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NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516		
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			<p>the requirement of proper placement of fire extinguisher, and importance of it remaining in its proper place.</p> <p>Maintenance Director, Laundry Supervisor, and ED or ED Designee to monitor fire extinguisher placement 5 days per week for 4 weeks and then during routine daily/weekly/or monthly maintenance rounds thereafter.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Maintenance Director, Laundry Supervisor, and ED or ED Designee to monitor fire extinguisher placement 5 days per week for 4 weeks and then during routine daily/weekly/or monthly maintenance rounds thereafter.</p> <p>Monthly reporting of fire extinguisher placement rounds to be made by the Maintenance Director to the CQI Committee for review and any necessary corrections.</p> <p>By what date the systemic changes will be completed: Compliance Date: 6/06/13</p>		

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure 26 of 26 hard wired smoke detectors in residents rooms were functional. 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 4.6.12.2 states existing life safety features obvious to the public shall be maintained. 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 at least 26 residents in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility from 12:45 p.m. to 2:45 p.m. on 05/07/13, the 26 resident room hard wired smoke detectors on the 200, 400 and 500 halls were without power and did not function when tested. Based on interview at the time of observation, the Maintenance Director acknowledged the smoke detectors were without power and</p>	K010130	<p>K130 – Hard Wired Smoke Detector Not Operating It is the practice of this provider to assure the safety of all residents, staff, and visitors by providing appropriate operating smoke detectors. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All 26 hard wired electrical smoke detectors were replaced by 10 year lithium battery operated smoke detectors. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this practice. All 26 hard wired electrical smoke detectors were replaced by 10 year lithium battery operated smoke detectors. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director or Designee to monitor all smoke detectors during routine daily/weekly/or monthly preventative maintenance rounds.</p>	06/06/2013

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	was unable to provide an explanation. 3.1-19(b) 3.1-19(ff)		How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Maintenance Director or Designee to submit report of monitoring rounds to monthly CQI Committee for review and any necessary corrective action. By what date the systemic changes will be completed: Compliance Date: 6/06/13		

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K010147 SS=F	<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 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect any resident, staff of visitor throughout the facility.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility at 10:35 a.m. on 05/07/13, the power supply for the magnetic door control system was plugged into a multiplug adapter which was then plugged into a six foot extension cord in the 100 hall electrical room. Based on interview, this was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>	K010147	<p>K0147 – Electrical Wiring and Equipment</p> <p>It is the intent of this provider to assure the safety of all residents, staff, and visitors by utilizing fixed wiring.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: H&G Services (provider of electrical wiring) was contracted to provide fixed wiring to the power supply to the magnetic door control system in the 100 hall electrical room.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this practice. H&G Services (provider of electrical wiring) was contracted to provide fixed wiring to the power supply to the magnetic door control system in the 100 hall electrical room.</p> <p>Maintenance Director conducted rounds throughout facility to ensure there were no additional multi-plug adapters</p>	06/06/2013			

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			<p>or extension cords being used. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director/Designee/and All Staff to monitor for use of any extension cord within facility during routine rounds. If extension cord is found it is to be removed immediately and reported to maintenance for provision of proper electrical supply.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Maintenance Director or Designee to submit report of any findings to monthly CQI Committee for review and any corrective action necessary.</p> <p>By what date the systemic changes will be completed: Compliance date = 6/6/13</p>	

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K010160 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observation, record review and interview; the facility failed to ensure 1 of 1 basement elevator equipment rooms was provided with an electrical shunt trip when provided with sprinkler coverage. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice would not affect residents since residents do not use the elevator but could affect staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility at 1:15 p.m. on 05/07/13, the basement elevator equipment room was</p>	K010160	<p>K0160 – Required Elevator Shunt Trip It is the practice of this provider assure the safety of all residents, staff, and visitors by providing the appropriate elevator shunt trip. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: IEI (provider of electrical services) has been contracted to provide and install an electrical shunt trip in elevator machine room. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this practice. IEI (provider of electrical services) has been contracted to provide and install an electrical shunt trip in elevator machine room. What measures will be put into place or what systemic changes will be made to</p>	06/06/2013			

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	<p>provided with a sprinkler. Based on interview at the time of observation, the Maintenance Director acknowledged it was unknown if a shunt trip for the elevator machine room sprinkler was provided. Furthermore, based on presurvey review, survey history indicates the basement elevator equipment room was cited for lack of sprinkler coverage in 2008 and again in 2012. Further interview with the Maintenance Director indicated a sprinkler in the basement elevator equipment room has been installed and removed on several occasions.</p> <p>3.1-19(b)</p>		<p>ensure that the deficient practice does not recur: Maintenance Director or Designee to monitor elevator mechanical room during routine preventative maintenance rounds, as well as, outside contractor to provide routine elevator inspections as required. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Maintenance Director or Designee to submit report of rounds findings to monthly CQI Committee for review and any necessary corrective action. By what date the systemic changes will be completed: Compliance Date 6/06/13</p>		