

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155072	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/13/2015
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NAME OF PROVIDER OR SUPPLIER  BEECH GROVE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/13/15</p> <p>Facility Number: 000029 Provider Number: 155072 AIM Number: 100275200</p> <p>At this Life Safety Code survey, Beech Grove Meadows 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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a</p>	K 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0018 SS=E Bldg. 01	<p>capacity of 133 and had a census of 108 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which is not sprinklered.</p> <p>Quality Review completed 11/18/15 - DA</p> <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 1¼ 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 4 of over 75 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 40 residents, staff and visitors.</p>	K 0018	<p>1. Deadboltlocking devices were removed from all noted locations including the ADNSoffice, AL Food Service Room, 2 kitchen entry doors adjacent to Dining Room, and replaced with positive latching devices on 11-13-15.</p> <p>2.All residents have the potential to beaffected. An audit</p>	12/13/2015			

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	<p>Findings include:</p> <p>Based on observations with the Director of Maintenance during a tour of the facility from 11:45 a.m. to 2:00 p.m. on 11/13/15, the following four corridor door locations were each equipped with a deadbolt locking device and were not equipped with a positive latching device which provided an impediment to closing and latching each door into the door frame:</p> <ul style="list-style-type: none"> <li>a. ADNS Office.</li> <li>b. Food Service room across from the Gathering Room in assisted living.</li> <li>c. each of two kitchen entry doors from the main dining room which was open to the corridor.</li> </ul> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned four corridor doors each had an impediment to closing and latching into the door frame.</p> <p>3.1-19(b)</p>		<p>of remaining facility doors was completed to ensure there were no further deadbolt locking devices in use elsewhere.</p> <p>3. The Director of Maintenance and all maintenance assistants were inserviced on the standard for K018 and the requirement of positive latching and lack of impediment.</p> <p>4. Positive latching closures for doors will be ensured to be in use on the Life Safety CQI and included in the CQI meeting monthly for 6 months at 90%, then quarterly for 6 months thereafter. Any issues identified through the CQI process will be addressed via Corrective Action Plan immediately.</p>		

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K 0025 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure openings through 1 of 16 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 22 residents, staff and visitors in the vicinity of the smoke barrier wall by Room 212.</p> <p>Findings include:</p>	K 0025	<p>1. The rated foam barrier was removed from the space surrounding the ducts and the datalines, and it was replaced with a rated fire caulk on 11-13-15.</p> <p>2. All residents have the potential to be affected. A visual inspection was completed for all other fire barriers to ensure no additional areas utilizing the rated fire foam remained.</p> <p>3. Vendors for IT, Heating and Air, and Fire System maintenance were sent communication requesting the use of a standard fire caulk in any work they complete that necessitates a breach of the fire barrier. In service training was provided to</p>	12/13/2015

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K 0029 SS=E Bldg. 01	<p>Based on observation with the Director of Maintenance during a tour of the facility from 11:45 a.m. to 2:00 p.m. on 11/13/15, the one inch annular space surrounding two eight inch in diameter ducts which penetrated the attic smoke barrier wall above the cross corridor door set by Room 212 was filled with foam.. In addition, a six inch hole for the passage of thirty data cables was also filled with foam at the aforementioned attic smoke barrier wall location. Based on interview at the time of observation, the Director of Maintenance stated he was unaware of the fire resistance rating of foam used in the attic smoke barrier wall and acknowledged the aforementioned holes in the attic smoke barrier wall did not maintain at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the</p>		<p>theDirector of Maintenance and Maintenance assistants to ensure the use of ratedcaulk in fire barriers, but to inspect the work of vendors to ensure thatappropriate materials are used and disclosed by vendor.</p> <p>4. Properly sealed breaches in the fire barrierswill be ensured appropriate on the Life Safety CQI and included in the CQImeeting monthly for 6 months, at 90% or greater then quarterly for 6 monthsthereafter. Any issues identified through the CQI process will be addressed viaCorrective Action Plan immediately.</p>	

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	<p>approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure corridor doors to 1 of 7 hazardous areas such as kitchen and fuel fired heater room were separated from other areas by self closing doors. Doors to hazardous areas are self closing or close automatically upon activation of the fire alarm system. This deficient practice could affect 30 residents, staff and visitors in the main dining room.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance during a tour of the facility from 11:45 a.m. to 2:00 p.m. on 11/13/15, each of two corridor doors to the kitchen from the main dining room were not provided with a self closing device. The main dining room is open to the corridor. The kitchen contained one natural gas fired water heater which was not in an enclosed room within the kitchen. Based on interview at the time of the observations, the Maintenance Director acknowledged the corridor doors to the aforementioned fuel fired heater</p>	K 0029	<p>1.The storage room door adjacent to the RiserRoom, was fitted with a self closing device on 11-14-15.</p> <p>2.All residents have the potential to beaffected. A visual inspection wascompleted for all other storage rooms with greater than 50 sq. ft. to ensurethe doors are outfitted with self closing devices.</p> <p>3.The Director of Maintenance and all maintenanceassistants were provided inservice training on the standard K029 including butnot limited to self closing smoke resisting partitions and doors.</p> <p>4.Ensuring that self closing smoke resistingpartitions and doors are in place for all storage areas with greater than 50sq. ft. will be ensured appropriate on the Life Safety CQI and included in theCQI meeting monthly for 6 months, at 90% or greater then quarterly for 6 monthsthereafter. Any issues identified through the CQI process will be addressed viaCorrective Action Plan immediately.</p>	12/13/2015

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	<p>room were each not equipped with a self closing device.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure corridor doors to 1 of 7 hazardous areas such as combustibile storage rooms over 50 square feet were provided with self closing devices. This deficient practice could affect 12 residents, staff and visitors in the vicinity of the storage room by the Riser Room containing the facility's automatic sprinkler system riser.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance during a tour of the facility from 11:45 a.m. to 2:00 p.m. on 11/13/15, the corridor door to the storage room by the Riser Room containing the facility's automatic sprinkler system riser was not provided with a self closing device. The storage room measured 150 square feet and was used to store combustibile boxes and medical supplies on shelving throughout the room. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned hazardous area corridor door was not equipped with a self closing device.</p>			

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K 0038 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 7 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 22 residents, staff and visitors using the exit by Room 212.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance during a tour of the facility</p>	K 0038	<p>1. Codenotification was posted on the keypad for exit to the Assisted Living was added on 11-13-15.</p> <p>2.All residents have the potential to beaffected. A visual inspection wascompleted for all locked exit doors to ensure code for release was posted.</p> <p>3.Inservice training was provided to the Directorof Maintenance and maintenance assistants for the Life Safety Code standardK038 including the requirements for release code posting for maglocked doors.</p> <p>4.The posting of exit codes for maglocked securitydoors will be ensured appropriate on the Life Safety CQI and included in theCQI meeting monthly for 6 months, at 90% or greater then quarterly for 6 monthsthereafter. Any issues identified through the CQI process will be addressed viaCorrective Action Plan immediately.</p>	12/13/2015

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K 0050 SS=C Bldg. 01	<p>from 11:45 a.m. to 2:00 p.m. on 11/13/15, the set of exit doors by Room 212 were marked as a facility exit, the exit door set was magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of observation, the Maintenance Director stated not all residents have a clinical diagnosis to be in a secure building, the residents which do have a clinical diagnosis to be in a secure building reside in the dementia wing in the 100 Hall and acknowledged the four digit code was not posted at the set of exit doors by Room 212. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p>			
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K 0062	<p>Based on record review and interview, the facility failed to document fire drills conducted on the third shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Report" documentation with the Director of Maintenance during record review from 9:25 a.m. to 11:45 a.m. on 11/13/15, documentation for the third shift fire drill conducted in the first quarter of 2015 on 02/16/15 did not include the time of day the fire drill was conducted. The aforementioned fire drill report stated is was a third shift fire drill but documentation of the time of day the fire drill was conducted was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the fire drill was conducted at 5:00 a.m. but acknowledged documentation of the time of day the aforementioned fire drill was conducted was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>	K 0050	<p>1. The FireDrill completed 2-16-15 was verified to have been completed at approximately 10:45 through record review.</p> <p>2. All residents have the potential to be affected. The Fire Drill completed 2-16-15 was verified to have been completed at approximately 10:45 through record review.</p> <p>3. Reviewing and scheduling fire drills will be added to the agenda of the Safety Committee meeting that is held monthly. Director of Maintenance received inservice training to appropriately schedule and document fire drills.</p> <p>4. The appropriate scheduling and documentation will be ensured appropriate on the Life Safety CQI and included in the CQI meeting monthly for 6 months, at 90% or greater then quarterly for 6 months thereafter. Any issues identified through the CQI process will be addressed via Corrective Action Plan immediately.</p>	12/13/2015	

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SS=E Bldg. 01	<p><b>LIFE SAFETY CODE STANDARD</b> 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 replace 2 of over 100 sprinklers which had become corroded, had paint, lint or other foreign materials on them. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 22 residents, staff and visitors in the vicinity of Room 131.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance during a tour of the facility from 11:45 a.m. to 2:00 p.m. on 11/13/15, two pendant sprinklers installed in the corridor outside Room 131 and outside Room 133 each had white paint on them. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned sprinkler locations had</p>	K 0062	<p>1. Sprinklerheads located outside Rooms 131 and 133 were replaced on 11-18-15.</p> <p>2. All residents living on that section of A-hall(22 residents) have the potential to be affected.</p> <p>3. A visual inspection was completed on all sprinkler heads and all heads identified to have paint or corrosion on them were replaced on 11-18-15. The Director of Maintenance and maintenance assistants were provided in service training on the standard for K062.</p> <p>4. The condition of the sprinkler heads will be ensured appropriate on the Life Safety CQI and included in the CQI meeting monthly for 6 months, at 90% or greater then quarterly for 6 months thereafter. Any issues identified through the CQI process will be addressed via Corrective Action Plan immediately.</p>	12/13/2015

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K 0064 SS=D Bldg. 01	<p>foreign materials attached to them.</p> <p>3.1-19(b)</p> <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 Based on observation and interview, the facility failed to inspect 1 of 1 portable K Class fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect five staff and visitors in the kitchen.</p> <p>Findings include:</p>	K 0064	<p>1. The fireextinguisher in the kitchen was inspected on 11-13-15.</p> <p>2.All residents have the potential to be affectedby this practice. The fire extinguisherin the kitchen was inspected on 11-13-15. A visual inspection was completed by the Director of Maintenance of allfire extinguishers was completed 11-13-15 to ensure all had had the requiredmonthly inspection completed.</p> <p>3.The Director of Maintenance and maintenanceassistance were provided inservice training on the standard for K064, the PMchecklist for extinguisher inspections, and locations of all the extinguisherswithin the facility.</p> <p>4.The timely inspections of all fire extinguisherswill be ensured appropriate on the Life Safety CQI and included in the</p>	12/13/2015

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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			
K 0069 SS=D Bldg. 01	<p>Based on observation with the Director of Maintenance during a tour of the facility from 11:45 a.m. to 2:00 p.m. on 11/13/15, the inspection tag affixed to the portable K Class fire extinguisher in the kitchen indicated a monthly inspection was not documented after March 2015. Based on interview at the time of observation, the Director of Maintenance stated no additional documentation of monthly fire extinguisher checks for the portable K Class fire extinguisher was available for review and acknowledged a monthly inspection for the aforementioned portable fire extinguisher was not documented after March 2015.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the</p>	K 0069	<p>CQI meeting monthly for 6 months, at 90% or greater then quarterly for 6 months thereafter. Any issues identified through the CQI process will be addressed via Corrective Action Plan immediately.</p> <p>1. The documentation for the hood inspections was retrieved from the service provider 11-13-15.</p> <p>2. All residents have the potential to be affected by this practice. The documentation for the hood inspections was</p>	12/13/2015			

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	<p>entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect five staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on record review with the Director of Maintenance from 9:25 a.m. to 11:45 a.m. on 11/13/15, documentation of semiannual kitchen exhaust systems inspections within the most recent twelve month period was not available for review. Based on observation with the</p>		<p>retrieved from the service provider 11-13-15.</p> <p>3.The Director of Maintenance and MaintenanceAssistants were provided inservice training related to documentation retentionfor all Preventative Maintenance inspections, activities, and routinerepair.</p> <p>4.The timely inspections of the stove hood, anddocumentation for such will be ensured appropriate on the Life Safety CQI andincluded in the CQI meeting monthly for 6 months, at 90% or greater thenquarterly for 6 months thereafter. Any issues identified through the CQIprocess will be addressed via Corrective Action Plan immediately.</p>	

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	<p>Director of Maintenance during a tour of the facility from 11:45 a.m. to 2:00 p.m. on 11/13/15, a sticker was affixed to the kitchen range hood indicating the most recent hood inspection was performed by Richard's Hood &amp; Duct in May 2015. No other kitchen exhaust systems inspection documentation within the most recent twelve month period was available for review. Based on interview at the time of record review and of the observation, the Director of Maintenance acknowledged documentation of semiannual kitchen exhaust systems inspection six months prior to May 2015 was not available for review.</p> <p>3.1-19(b)</p>						
K 0072 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure 2 of 5 means of egress was continuously maintained free</p>	K 0072	1. Both the photocopy machine and the hydration station were relocated on 11-13-15.	12/13/2015			

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	<p>of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 76 residents, staff or visitor if needing to exit the facility.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance during the initial walk through of the facility at 9:10 a.m. on 11/13/15, a three foot tall by five foot long chest of drawers which projected sixteen inches into the corridor was observed being stored in the corridor outside the main dining room. In addition, a four foot tall by four foot wide photocopying machine which was plugged into an electrical outlet and projected two feet into the corridor was observed being stored in the corridor outside Physical Therapy. Based on observations with the Director of Maintenance during a tour of the facility from 11:45 a.m. to 2:00 p.m. on 11/13/15, the aforementioned two items which were observed stored in the corridor during the initial walk through were observed stored in the same locations. Based on interview at the time of the observations, the Director of Maintenance stated the chest of drawers in the corridor outside the main dining room is a hydration station and</p>		<p>2.All residents have the potential to be affectedby this practice. Both the photocopymachine and the hydration station were relocated on 11-13-15.</p> <p>3.The Director of Maintenance and MaintenanceAssistants were provided inservice training related to the maintaining of obstructionand impediment free egress routes.</p> <p>4.Impediment and obstruction free routes of egresswill be ensured appropriate on the Life Safety CQI and included in the CQImeeting monthly for 6 months, at 90% or greater then quarterly for 6 monthsthereafter. Any issues identified through the CQI process will be addressed viaCorrective Action Plan immediately.</p>	

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K 0130 SS=E Bldg. 01	<p>acknowledged corridor storage at the aforementioned locations would provide an obstruction or impediment to residents, staff and visitors in the case of fire or other emergency.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review, observation and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors were in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall</p>	K 0130	<p>1. Therolling fire door in the kitchen pass-through window installed in September of2014, was inspected on 11-18-15.</p> <p>2.All residents have the potential to be affectedby this practice. The rolling fire doorin the kitchen pass-through window installed in September of 2014, wasinspected on 11-18-15.</p> <p>3.The Director of Maintenance received inservicetraining related to the Preventative Maintenance Log and Schedule as itpertains to the rolling fire door in the kitchen pass through.</p> <p>4.Annual inspections of the rolling fire door willbe ensured appropriate on the Life Safety</p>	12/13/2015

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	<p>be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 30 residents, staff and visitors in the main dining room.</p> <p>Findings include:</p> <p>Based on record review with the Director of Maintenance from 9:25 a.m. to 11:45 a.m. on 11/13/15, documentation of kitchen rolling fire door inspection and testing within the most recent twelve month period was not available for review. Based on observation with the Director of Maintenance during a tour of the facility from 11:45 a.m. to 2:00 p.m. on 11/13/15, one metal rolling fire door protecting the opening from the kitchen to the main dining room which was open to the corridor was noted. No inspection tag was affixed to the rolling fire door. Based on interview at the time of record review and of the observations, the Director of Maintenance acknowledged documentation of kitchen rolling fire door inspection and testing within the most recent twelve month period was not available for review.</p> <p>3.1-19(b)</p>		<p>CQI and included in the CQI meeting monthly for 6 months, at 90% or greater then quarterly for 6 months thereafter. Any issues identified through the CQI process will be addressed via Corrective Action Plan immediately.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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