

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/08/2013
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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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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: 05/08/13</p> <p>Facility Number: 000034 Provider Number: 155086 AIM Number: 100274880</p> <p>Surveyors: Dennis Austill, Life Safety Code Supervisor; Robert Sutton, Life Safety Code Specialist Trainee</p> <p>At this Life Safety Code survey, Woodland Manor 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 was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and areas open to the corridor. Battery operated smoke detectors were in</p>	K010000		

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>all 48 resident rooms. The facility has a capacity of 80 and had a census of 58 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two detached buildings providing facility storage.</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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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 3 of 7 smoke barriers were 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 30 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 the facility from 9:15 a.m. to 12:00 p.m.</p>	K010025	<p>Preparation and /or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K-025 Smoke penetrations/Smoke barriers</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>1.) The penetrations from the 3 of the 7 smoke barriers have been filled with a fire proof caulk.</p> <p>2.) The 10 foot section of double layer drywall has been reattached and all smoke penetrations have been filled with fire proof caulking.</p>	06/07/2013	

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	<p>on 05/08/13, there were exposed penetrations through the smoke barriers above the ceiling tiles at the following locations that were not firestopped:</p> <p>a. The Unit 1 east drywall smoke barrier had a two inch annular space around a conduit penetration near room 117 that was not sealed.</p> <p>b. The Unit 2 south concrete block smoke barrier near room 229 had a one inch annular space around a conduit penetration that was not sealed. Additionally at the same barrier, along the entire length of the fire wall, there was an added double layer of drywall to close up the gap between the top of the block wall and the roof deck. There was a ten foot long, section of the double-layer of dry wall that had fallen off at the top of the barrier and was now laying at the bottom of the barrier wall.</p> <p>c. The Unit 4 north concrete block smoke barrier above the medical records office had a three inch annular space around an electrical conduit that was not sealed. Based on interview during the times of observation, the Maintenance Director acknowledged the unprotected openings through the smoke barriers.</p> <p>3.1-19(b)</p>		<p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: A facility wide audit was completed to locate any other areas for a breach in the smoke barrier or any areas where the double layer fire walls are out of place or fallen . None were found.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: The maintenance director has been re-educated in the components of this tag. The standard monitoring and any needed adjustments identified will be during routine life safety, monthly preventive maintenance rounds as the maintenance director/designee checks for smoke penetrations or any double layer fire walls that are out of place and not providing a smoke free barrier.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. what quality assurance program will be put into place: The NHA/maintenance director</p>		

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			<p>will make weekly walking rounds to check for any smoke penetrations in smoke barriers for the next four (4) weeks and bi-monthly for Two (2) months. A quarterly monitoring by the director of plant operations/designee will be conducted. A report of their findings will be discussed at the monthly Risk management/QA meeting to determine when compliance has been met.</p> <p>(e) Date of compliance: 6/7/13</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 1 of 8 doors serving hazardous areas closed and latched to prevent the passage of smoke. This deficient practice would not affect residents but could affect staff in and near the back service hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility at 10:15 a.m. on 05/08/13, the housekeeping supply room exceeded 50 square feet and the door was not provided with a door closer. The room was used for the storage of combustible boxes and paper supplies. Based on interview during the time of observation, the Maintenance Director acknowledged the door to this room lacked a door closer and would need to be manually pulled shut to</p>	K010029	<p>Preparation and /or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K-029 Hazardous areas separation</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: A door closer was installed on the housekeeping supply room door and checked for positive lock and latch.</p> <p>(b) How you will identify other residents having potential to be affected by the same</p>	06/07/2013			

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	latch the door. 3.1-19(b)		<p>practice and what corrective action will be taken: A facility wide audit was completed to identify any other hazardous rooms that may require a door closer. None were found.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: The maintenance director has been in-serviced as to the required components of this tag. The standard monitoring and any needed adjustments identified will be during routine life safety, monthly preventive maintenance rounds as the maintenance director/designee checks for doors that may require a door closures.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. what quality assurance program will be put into place: The NHA and/or maintenance director will make weekly walking rounds to make sure the door closure is functioning properly on the housekeeping supply room door for the next Four (4) weeks and bi-monthly for Two (2) months. A quarterly</p>		

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			<p>monitoring by the director of plant operations/ designee will be conducted. A report of their findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met.</p> <p>(e) Date of compliance: 6/7/13</p>	

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure the means of egress through 2 of 8 exits was 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 requires 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 residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice affects at least 25 of 58 residents on Unit 1, Unit 3 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 12:00 p.m. on 05/08/13, the following was noted:</p> <p>a. The Unit 3 north set of smoke barrier doors were provided with magnetic locks and could be opened by entering a four</p>	K010038	<p>A Preparation and /or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K-038 Door signage</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>1.) The code to the exit door at unit Three (3) has been conspicuously posted with the four (4) digit code.</p> <p>2.) The code to the exit door at unit one (1) has been conspicuously posted with the four (4) digit code.</p> <p>3.) A sign has been placed conspicuously at the unit (1) and (2) ambulance entrance/exit door with a (4) digit code.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>Any resident, visitor, vender, or</p>	06/07/2013			

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	<p>digit code which was not posted. Based on interview of the Maintenance Director at the time of observation, there were 8 residents on Unit 3 and none had a clinical diagnosis requiring specialized security measures. Any resident without a clinical diagnosis requiring specialized security measures or any visitor would have to ask a staff member for exit access if they did not know the code.</p> <p>b. The Unit 1 east exit access door was magnetically locked and could be opened by entering a four digit code which was not posted. Based on interview of the Unit 1 charge nurse at the time of observation, there were 19 residents on Unit 1 and only 2 residents on Unit 1 had a clinical diagnosis requiring specialized security measures. Any resident without a clinical diagnosis requiring specialized security measures or any visitor would have to ask a staff member for exit access if they did not know the code.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 exits was readily accessible at all times. This deficient practice could affect at least eight residents on Unit 3.</p>		<p>employee has the potential to be affected, but none were identified.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>1.) The importance of this regulation has been reviewed with the maintenance director and during his daily rounds he will assure the proper signage is correct, in place and being followed.</p> <p>2.) The importance of this regulation has been reviewed with the maintenance director and during his daily rounds he will assure the proper signage is correct, in place and being followed.</p> <p>3.) The maintenance director has been educated on this standard and will assure the signage is in place and correct at the unit 1 and 2 ambulance entrance/exit.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. What quality assurance program will be put into place: The monitoring of this tag will be a joint effort between the NHA and the maintenance director as they make their</p>				

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility at 10:45 a.m. on 05/08/13, the Unit 3 east exit access door was magnetically locked, had a four digit code which was not readily visible and did not release the door when the code was entered. When the code was entered, the door alarm beeped but the magnet did not release. This was confirmed by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 8 exit doors were accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice affects at least 30 residents on Units 1 and 2 and any visitors.</p>		<p>daily rounds which will include a visual check for proper exit signage of the doors on unit 3, 1 and 2 and proper operation. They will review this standard at the monthly Risk Management meeting to assure they maintain compliance.</p> <p>(e) Date of compliance: 6/7/13</p>				

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility at 10:30 a.m. on 05/08/13, the Unit 1 and 2 Ambulance exit door was equipped with an electromagnetic lock that released in 15 seconds when tested by the Maintenance Director. The door lacked a sign that reads "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS." This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>				

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K010045 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to ensure the lighting for 1 of 8 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect at least 8 residents, as well as staff, and visitors if needing to exit the facility from the Unit 3 east exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility at 9:40 a.m. on 05/08/13, one of two bulbs in the exterior light fixture at the Unit 3 east exit was burned out. This was confirmed by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>	K010045	<p>Preparation and /or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K-045 Illumination of egress</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: The burnt light bulb was replaced with a new working light bulb.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Any resident, visitor, vender or staff has the potential to be affected, but none were identified.</p> <p>(c) What measures will be put</p>	06/07/2013

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			<p>into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>The maintenance director has been re-educated as to the required components of this tag. The standard monitoring and any needed adjustments identified will be during routine life safety and preventive maintenance rounds as the maintenance director checks all outside egress lighting for proper coverage and illumination.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. what quality assurance program will be put into place: The monitoring of this tag will be a joint effort between the NHA and maintenance director. This will be an ongoing standard and checked by the director of plant operations/designee. Their findings will be discussed at the monthly Risk Management/ QA meeting to assure the facility remains in compliance.</p> <p>(e) Date of compliance: 6/7/13</p>		

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K010048 SS=F	<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 ensure 1 of 1 written fire safety plans for the facility included staff response to alarms and extinguishment of fire. LSC 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice affects all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire safety plan and policy and procedures from 9:00 a.m. to 12:00 p.m. on 05/08/13, the following was noted:</p> <ol style="list-style-type: none"> a. The fire safety plan did not address the use of the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead 	K010048	<p>Preparation and /or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K-048 Written fire safety plan</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>a.) Dietary staff has been educated in the use of the K-series fire extinguisher pertaining to the ansul system. It has been added to the fire plan.</p> <p>b.) The fire plan has been modified for staff to respond to a battery operated smoke detector the same as the fire alarm system. If it annunciates initiate R.A.C.E and P.A.S.S. procedures.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p>	06/07/2013			

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	<p>extinguishing system.</p> <p>b. The fire safety plan did not address staff response to battery operated resident room smoke detectors.</p> <p>Based on interview at 12:05 p.m., the Maintenance Director acknowledged the written fire safety plan for the facility did not include use of the K-class fire extinguisher or staff response to battery operated smoke detectors in the resident rooms. This was acknowledged again by the Administrator during the exit conference at 12:30 p.m.</p> <p>3.1-19(b)</p>		<p>Any resident, visitor, vender or staff has the potential to be affected, but were identified.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Staff has been in-serviced on the K-series fire extinguisher and battery operated smoke detectors as to what there purpose is and what their responses are pertaining to R.A.C.E. and P.A.S.S.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. what quality assurance program will be put into place: The monitoring of this tag will be a joint effort between the NHA and the maintenance director as they will make their daily walking rounds and spot check the education of the staff on the K-series fire extinguisher and battery operated smoke detectors. The will review their findings at the monthly Risk Management/QA meeting. This will be an on-going standard.</p> <p>(e) Date of compliance: 6/7/13</p>		

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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 2 of 30 smoke detectors 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>Preparation and /or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K-051 Fire alarm system devices/ components</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: The smoke detectors to close to air return vents unit 4 East access and corridor located by</p>	06/07/2013			

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	<p>Based on observation with the Maintenance Director during the tour of the facility from 9:15 a.m. to 12:00 p.m. on 05/08/13, a corridor smoke detector located near the Unit 4 east access control doors was six inches from an air return vent and a corridor smoke detector located near room 117 was one foot from an air return vent. Based on interview at the time of observation, the Maintenance Director acknowledged the distances between the vent and agreed the air flow could interfere with smoke detector function.</p> <p>3.1-19(b)</p>		<p>room 117 have been moved to at least 36 inches from return air vents.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: A facility wide audit was conducted to locate any other smoke detector devices that are closer than 36 inches to any air return or any other vents. None were found.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: The maintenance director has been educated to the required components of this tag. The standard monitoring and any needed adjustments identified will be done during routine life safety, monthly preventive maintenance rounds to check any smoke detectors that are closer than 36 inches to any air vent.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. what quality assurance</p>		

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			<p>program will be put into place: The monitoring of this tag will be a joint effort between the NHA and the maintenance director as they make their daily walking rounds for the next four weeks and bi-monthly for two months. A report of their findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met.</p> <p>(e) Date of compliance: 6/7/13</p>		

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, to provide complete coverage for all portions of the building. NFPA 13, Section 5-6.3.4, "Minimum Distance between Sprinklers", states sprinklers shall be spaced not less than 6 feet on center. In addition, LSC 19.1.1.4.5 requires minor renovations, alterations, modernizations, or repairs shall not reduce life safety below the level that previously existed. This deficient practice could affect any residents, staff or visitors in the main entrance lobby.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of</p>	K010056	<p>Preparation and /or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K-056 Automatic sprinkler system coverage</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>1. Two of the three sprinkler heads were moved for proper coverage and compliance to be at least six (6) feet apart in the front lobby area.</p>	06/07/2013			

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	<p>the facility at 11:05 a.m. on 05/08/13, two of three sprinklers in the main entrance lobby were four feet apart. Based on interview, the Maintenance Director acknowledged the distance between the two sprinkler heads and agreed the distance was less than six feet.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>2. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, to provide complete coverage for all portions of the building. NFPA 13, Section 5-1.1(3) states, sprinklers shall be positioned and located so as to provide satisfactory performance with respect to activation time and distribution. This deficient practice was not in a resident area and would mainly affect staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during the tour of the facility at 10:15 a.m. on 05/08/13, at least half of the liquid filled glass bulb for a sidewall sprinkler in the housekeeping supply room was located inside the concrete block wall with only the deflector extending from the wall. Based</p>		<p>2. The sprinkler in the block wall in the housekeeping closet has been moved to extend out of the block wall for proper coverage.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: A facility wide audit was conducted to check all sprinklers for improper coverage. None were found.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: The maintenance director has been re-educated as to the components of this tag. The standard monitoring and any needed adjustments identified will be done during routine life safety, monthly preventive maintenance rounds as to proper sprinkler coverage in all areas.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. what quality assurance</p>		

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	<p>on interview, the Maintenance Director acknowledged at least half of the sprinkler was located inside the concrete block wall.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>program will be put into place: The monitoring of this tag will be a joint effort between the NHA and the maintenance director as they make their daily walking rounds. They will review their findings at the monthly Risk Management/QA meeting to determine when compliance has been met. This will be an on-going standard.</p> <p>(e) Date of compliance: 6/7/13</p>		

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K010147 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 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 5 to 10 residents, staff or visitors in the east corridor.</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 12:00 p.m. on 05/08/13, a household extension cord was in use in the Environmental Services office providing power to a radio and another household extension cord was in use in resident room 100 providing power to a fan and a clock. Based on interview, this was acknowledged by the Maintenance Director at the time of observation.</p>	K010147	<p>Preparation and /or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K-147 Electrical wiring/Standard</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: The household extinction cord has been removed from the environmental services office and resident room 100.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: A facility audit was completed to locate any other extinction cords. None were found.</p> <p>(c) What measures will be put into place or what systematic changes you will make to</p>	06/07/2013			

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	3.1-19(b)		<p>ensure that the practice does not recur:</p> <p>The maintenance director has been re-educated as to the required components of this tag. The standard monitoring and any needed adjustments identified will be done during routine life safety, preventive maintenance rounds as the maintenance director checks for extinction cords.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. what quality assurance program will be put into place: The monitoring of this tag will be a joint effort between the NHA and the maintenance director as they do their daily walking rounds. This will be an on-going standard and will be reviewed at the monthly Risk Management/QA meeting to assure that compliance is being met.</p> <p>(e) Date of compliance: 6/7/13</p>		

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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 provide a complete written policy containing procedures to be followed to protect 58 of 58 residents in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's "Fire Watch" policy and procedure on 05/08/13 during paperwork review at 10:00 a.m., the fire watch procedure for an out of service automatic sprinkler system was not complete. The procedure indicated it is the policy of this provider to implement a fire watch in case of emergency situations in which the fire suppression and/or the fire alarm system are out of service for a period of time of four hours or more. Based on interview at 12:05 p.m., the Maintenance Director</p>	K010154	<p>Preparation and /or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K-154 Automatic sprinkler system repair</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: The phrase when placed out of service for 4 hours or more within a 24 hour period has been added to the fire plan.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Any resident, visitor, vender or staff has the potential to be</p>	06/07/2013			

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	<p>acknowledged the fire watch policy and procedure omitted the requirement for initiating a fire watch when the sprinkler system was out of service for four hours or more in a 24 hour period.</p> <p>3.1-19(b)</p>		<p>affected, but none were identified.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: The administrator and maintenance director have been educated to the required components of this tag,</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. what quality assurance program will be put into place: The monitoring of this tag will be a joint effort between the NHA and the maintenance director. A review will be held at the monthly Risk Management/QA meeting to assure they maintain compliance.</p> <p>(e) Date of compliance: 6/7/13</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 containing procedures to be followed to protect 58 of 58 residents in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's "Fire Watch" policy and procedure on 05/08/13 during paperwork review at 10:00 a.m., the fire watch procedure for an out of service fire alarm system was not complete. The procedure indicated it is the policy of this provider to implement a fire watch in case of emergency situations in which the fire suppression and/or the fire alarm system are out of service for a period of time of four hours or more. Based on interview at 12:05 p.m., the Maintenance Director acknowledged the fire watch policy and procedure omitted the requirement for</p>	K010155	<p>Preparation and /or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K-155 Automatic sprinkler system repair</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: The phrase when placed out of service for 4 hours or more within a 24 hour period has been added to the fire plan.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Any resident, visitor, vendor or staff has the potential to be affected, but none were</p>	06/07/2013			

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	<p>initiating a fire watch when the sprinkler system was out of service for four hours or more in a 24 -hour period.</p> <p>3.1-19(b)</p>		<p>identified.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: The administrator and maintenance director have been educated to the required components of this tag.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. what quality assurance program will be put into place: The monitoring of this tag will be a joint effort between the NHA and the maintenance director. A review will be held at the monthly Risk Management/QA meeting to assure that they maintain compliance</p> <p>(e) Date of compliance: 6/7/13</p>		