

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/20/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052
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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: 11/20/15</p> <p>Facility Number: 000468 Provider Number: 155378 AIM Number: 100290270</p> <p>At this Life Safety Code survey, Signature Health Care at Parkwood 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), and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in Maplewood Hall sleeping rooms and has battery operated smoke detectors installed in all other</p>	K 0000	<p>The facility requests that this plan of correction be considered it's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of the deficiencies. The plan of correction is prepared and/or executed solely because of federal and state law.</p>	

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 0017 SS=E Bldg. 01	<p>resident sleeping rooms. The facility has a capacity of 138 and had a census of 102 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were fully sprinklered.</p> <p>Quality Review completed 11/24/15 - DA</p> <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 1 corridors open to the freezer access area outside the kitchen was provided with an electrically supervised automatic smoke detection system. Exception No. 1 to LSC Section 19.3.6.1 states smoke compartments protected throughout by an approved,</p>	K 0017	<p>1. What was done to correct the deficient practice for the resident(s) identified?</p> <p>a. Automatic smoke detector to be installed in the corridor open to the freezer access outside the kitchen entrance.</p>	12/20/2015

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	<p>supervised automatic sprinkler system in accordance with 19.3.5.3 shall be permitted to have spaces open to the corridor provided the following criteria are met:</p> <p>(a) the spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) the corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4 or the smoke compartment in which the space is located is protected throughout by quick response sprinklers. (c) the open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4 or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) the space does not obstruct access to required access.</p> <p>This deficient practice could affect 10 residents, staff and visitors in the vicinity of the corridor outside the kitchen with freezer access.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Plant Operations Director from 12:45 p.m. to 3:05 p.m. on</p>		<p>2. How are others identified who would be effected by the deficient practice?</p> <p>a. Plant Operations Director completed an audit for all facility corridors to have a supervised automatic smoke detection system in place.</p> <p>3. What systemic Changes have been made to ensure the deficient practice does not continue.</p> <p>a. Plant Operations Director completed an audit all facility corridors to ensure automatic smoke detectors are present.</p> <p>4. How are you going monitor (audit) to ensure the deficient practice is fixed?</p> <p>a. Plant operations Director will conduct an audit monthly to ensure all facility corridors have automatic smoke detection devices. Results of the audits will be reported monthly to Quality Assurance Performance Improvement Committee (QAPI) for monitoring and any needed interventions. Monthly audits will continue until there are two consecutive months of 100% audits, audits will continue quarterly thereafter.</p>	

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K 0025 SS=E Bldg. 01	<p>11/20/15, the freezer access area outside the kitchen is open to the corridor because the east door in the corridor door set for the freezer access area does not latch into the west door. The latching mechanism in the east door was "dogged down" and the west door in the door set does not have a latching plate and opening for a latching mechanism. The freezer access area corridor is not provided with an electrically supervised automatic smoke detection system. The automatic sprinkler system observed in the aforementioned corridor was not equipped throughout with quick response sprinklers and is not arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. Based on interview at the time of the observations, the Plant Operations Director acknowledged the aforementioned area is open to the corridor and is not provided with an electrically supervised automatic smoke detection system.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum</p>			

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	<p>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 10 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 20 residents, staff and visitors in the vicinity of the smoke barrier wall in the Redwood South Hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Operations Director from 12:45 p.m. to 3:05 p.m. on 11/20/15, a three foot high by two foot wide hole was noted in the attic smoke barrier wall above the corridor door set by Room 60 in the Redwood South Hall. The aforementioned corridor doors in the door set each had an affixed label stating the door had a 90 minute fire resistance</p>	K 0025	<p>1. What was done to correct the deficient practice for the resident(s) identified? a. 3'x2' hole in attic in attic smoke barrier has been repaired. 2. How are others identified who would be effected by the deficient practice? a. Plant Operations Director has checked all other smoke barriers throughout the facility for any other holes and none were found. 3. What systemic Changes have been made to ensure the deficient practice does not continue. a. Plant Operations Director or designee will conduct an audit of all attic smoke barriers after a contractor has been in the attic to ensure no holes in smoke barriers are present. 4. How are you going monitor (audit) to ensure the deficient practice is fixed? Plant Operations Director or designee will conduct an audit of all attic smoke barriers monthly for holes in smoke barriers. Results of the audits will be reported monthly to Quality Assurance Performance Improvement Committee for monitoring and any needed interventions. Monthly audits will continue until there are two consecutive months of 100% audits, audits will continue quarterly thereafter.</p>	12/20/2015

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K 0038 SS=E Bldg. 01	<p>rating. Based on interview at the time of observation, the Plant Operations Director acknowledged the aforementioned opening in the Redwood South Hall attic smoke barrier wall did not maintain the fire resistance rating of the smoke barrier wall.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 13 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 20 residents, staff and visitors using the exit</p>	K 0038	<p>1. What was done to correct the deficient practice for the resident(s) identified?</p> <p>a. Magnetically locked door code has been posted at the Redwood South door.</p> <p>1.How are others identified who would be effected by the deficient practice?</p> <p>1.Plant Operations Director has completed an audit of all magnetically operator door for code posted and no other doors were found.</p>	12/20/2015

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K 0048 SS=C Bldg. 01	<p>door set by Room 60.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Operations Director from 12:45 p.m. to 3:05 p.m. on 11/20/15, the set of exit doors by Room 60 in the Redwood South Hall 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 Plant Operations 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 Rosewood Hall and acknowledged the four digit code was not posted at the set of exit doors by Room 60 in the Redwood South Hall. 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 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</p>		<p>1.What systemic Changes have been made to ensure the deficient practice does not continue.</p> <p>1.Plant Operations Director will complete an audit of all magnetically operated doors to ensure codes are posted.</p> <p>4. How are you going monitor (audit) to ensure the deficient practice is fixed? Plant Operations Director or designee will conduct an audit of all magnetically operated doors to ensure codes are posted. Results of the audits will be submitted to Quality Assurance Performance Improvement (QAPI) Committee of monitoring and any needed interventions. Monthly audits will continue until there are two consecutive months of 100 % compliance, then quarterly thereafter.</p>	
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	<p>1. Based on record review, observation and interview; the facility failed to develop a written fire safety plan for staff response to the activation of battery operated smoke detectors installed in 65 of 75 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <p>(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> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Disaster Preparedness: Fire Safety Plan and Procedure" documentation with the Plant Operations Director during record review from 9:20 a.m. to 12:05 p.m. on 11/20/15, the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms. Under "Section 8(d) Life Safety</p>	K 0048	<p>1. What was done to correct the deficient practice for the resident(s) identified?</p> <p>a. The facility Disaster Preparedness: Fire Safety Plan and procedure has been revised for staff response to the activation of a battery operated smoke detector. All Fire and Disaster Policy Manuals have been updated to reflect changes in the policy</p> <p>b. The facility Disaster Preparedness: Fire Safety Plan has been revised to reflect activation of the fire suppression system first when there is a fire in the hood removal system or in the oven/deep fat fryer area and it is unsafe to fight the fire with an extinguisher. All Fire and Disaster Policy Manuals have been updated to reflect changes in the policy.</p> <p>2. How are others identified who would be effected by the deficient practice?</p> <p>a. Staff Development Coordinator will educate all facility staff on the response to the activation of a battery powered smoke detector. Staff Development Coordinator will review at all new staff orientation.</p> <p>b. A review of the fire safety policies found no other needed changes.</p>	12/20/2015

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	<p>Equipment" of the aforementioned written fire safety plan, it is stated "This facility is equipped with battery backup smoke detectors" with no staff response to their activation. Based on observations during a tour of the facility with the Plant Operations Director from 12:45 p.m. to 3:05 p.m. on 11/20/15, battery operated smoke detectors are installed in all resident sleeping rooms except for Maplewood Hall. Based on interview at the time of record review, the Plant Operations Director acknowledged the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms.</p> <p>3.1-19(a)</p> <p>2. Based on record review, observation and interview; the facility failed to accurately include the use of the kitchen range hood fire suppression system in relation to kitchen fire extinguishers for 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department</p>		<p>3. What systemic Changes have been made to ensure the deficient practice does not continue.</p> <p>a. The facility Disaster Preparedness: Fire Safety Plan and Procedure has been updated to include staff response to battery powered smoke detector activation.</p> <p>b. Staff Development Coordinator will educate all facility staff on changes in firefighting policy for fires in the kitchen. Education will occur for all staff on firefighting policies in the kitchen.</p> <p>4. How are you going monitor (audit) to ensure the deficient practice is fixed?</p> <p>a. Staff Development Coordinator will submit new staff education log to Quality Assurance Performance Improvement Committee (QAPI) for staff response to battery powered smoke detector activation.</p> <p>b. Dietary Manager will complete a monthly audit dietary staff to ensure they understand the changes in fire fighting policy for fires in the kitchen. Results of the audits will be submitted monthly to the Quality Assurance Performance Improvement Committee (QAPI) to monitor for compliance and any needed further intervention. Once there has been two consecutive months of 100 % compliance, audits will</p>				

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	<p>(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 This deficient practice could affect 5 staff in the kitchen.</p> <p>Findings include:</p> <p>Based on review of "Disaster Preparedness: Fire Safety Plan and Procedure" documentation with the Plant Operations Director during record review from 9:20 a.m. to 12:05 p.m. on 11/20/15, the "Dietary Staff" section of the written fire safety plan stated "If the fire is located in the kitchen area, pull the fire alarm and immediately fight the fire with the appropriate fire extinguisher. If the fire is located in the hood removal system or in the oven/deep fat fryer area and unsafe to fight with an extinguisher, pull the handle to activate the hood suppression system and then exit the building". Based on observation during a tour of the facility with the Plant Operations Director from 12:45 p.m. to 3:05 p.m. on 11/20/15, a portable K Class fire extinguisher was located in the kitchen and a placard was conspicuously placed near the extinguisher which states</p>		be completed annually for all staff thereafter.				

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K 0050 SS=F Bldg. 01	<p>the fire protection system shall be activated prior to using the fire extinguisher. Based on interview at the time of record review and observation, the Plant Operations Director acknowledged the written fire safety plan did not accurately address the use of the kitchen range hood fire suppression system in relationship with the use of the kitchen K class fire extinguisher in the aforementioned written fire safety plan under the "Dietary Staff" section.</p> <p>3.1-19(a)</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> <p>1. Based on record review and interview, the facility failed to document fire drills conducted on the first and third shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p>	K 0050	<p>1. What was done to correct the deficient practice for the resident(s) identified?</p> <p>a. There has been a fire drill conducted on each shift for each quarter since April 2015.</p>	12/20/2015

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	<p>Based on review of Direct Supply TELS "Logbook Documentation: Fire Drills" with the Plant Operations Director during record review from 9:20 a.m. to 12:05 p.m. on 11/20/15, documentation of a fire drill conducted on the first shift and on the third shift in the first quarter of 2015 was not available for review. Based on interview at the time of record review, the Plant Operations Director acknowledged documentation of a fire drill conducted on the aforementioned two shifts in the first quarter of 2015 was not available for review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to document activation of the fire alarm system for second shift fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in</p>		<p>b. Fire Drill of the fire alarm was conducted 11.30.15 at 8:30 PM and it included the transmission of the fire signal and simulation of emergency fire conditions.</p> <p>2. How are others identified who would be effected by the deficient practice?</p> <p>a. An Audit was conducted of all Fire Drills from April 2015 to present and there has been a fire drill on each for quarter.</p> <p>b. Plant Operations and designee were educated on all Drills between 6:00 AM and 9:00 PM will include transmission of the fire alarm signal and simulation of emergency fire condition.</p> <p>3. What systemic Changes have been made to ensure the deficient practice does not continue.</p> <p>a. Plant Operations Director or designee will conduct Fire Drills Quarterly on each shift and will include transmission of the fire signal and simulation of emergency fire condition.</p> <p>b. Plant Operations Director will complete an audit of all fire drills to ensure each fire drill includes alarm signal and simulation of emergency fire conditions.</p> <p>4. How are you going monitor</p>	

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K 0052 SS=F Bldg. 01	<p>the facility.</p> <p>Findings include:</p> <p>Based on review of Direct Supply TELS "Logbook Documentation: Fire Drills" with the Plant Operations Director during record review from 9:20 a.m. to 12:05 p.m. on 11/20/15, documentation for the second shift fire drill conducted on 10/11/15 at 8:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal. The aforementioned fire drill documentation stated "nite drill" and "911/Monitoring Company 10/12/15 received 11:06 am cleared 11:11 am". Based on interview at the time of record review, the Plant Operations Director stated he was unaware fire drills conducted before 9:00 p.m. must include fire alarm system activation and acknowledged documentation for the aforementioned second shift fire drill conducted after 6:00 a.m. but before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is</p>		<p>(audit) to ensure the deficient practice is fixed?</p> <p>a. Plant Operations Director or designee will report results of Fire Drills to Quality Assurance Performance Improvement Committee (QAPI) to ensure quarterly fire drills have been conducted on each shift for each quarter. The QAPI Committee will monitor for compliance and intervene as needed.</p> <p>b.Plant Operations Director will complete an audit of all fire drills to ensure each fire drill includes alarm signal and simulation of emergency fire conditions. Results of the audit will be submitted to the Quality Assurance Performance Improvement Committee (QAPI) monthly monitoring and any needed follow-up. Once there has been two consecutive months of 100% compliance audits will be submitted quarterly thereafter</p>		

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	<p>installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review, observation and interview; the facility failed to ensure documentation of annual functional testing for all facility smoke detectors was maintained. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors are tested annually. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Fire Equipment Service Company (FESCO) "Fire Alarm Inspection" documentation dated 05/20/15, 08/13/15 and 11/11/15 with the Plant Operations Director during record review from 9:20 a.m. to 12:05 p.m. on 11/20/15, it could not be assured all facility duct detectors were documented as being functional tested annually. The aforementioned three inspection reports did not reference any duct detector locations as being functionally tested. Based on observation during a tour of the facility with the Plant Operations Director from 12:45 p.m. to 3:05 p.m. on</p>	K 0052	<p>1. What was done to correct the deficient practice for the resident(s) identified?</p> <p>a. Contractor completed on 12.03.15 a functional test for the duct detector in the furnace room located near the Chaplain's Office.</p> <p>2. How are others identified who would be effected by the deficient practice?</p> <p>a. Plant Operations Director completed a facility audit for duct detectors with the contractor on 12.03.15, no others were found</p> <p>3. What systemic Changes have been made to ensure the deficient practice does not continue.</p> <p>a. Plant Operations Director or designee will conduct a annual audit to ensure duct detectors are functionally tested.</p> <p>4. How are you going monitor (audit) to ensure the deficient practice is fixed? Plant Operations Director or designee will complete an audit of functional testing of duct detectors. Results of the audit will</p>	12/20/2015

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K 0062 SS=F Bldg. 01	<p>11/20/15, a duct detector was observed in the furnace room by the Chaplains Office. Based on interview at the time of record review and at the time of observation, the Plant Operations Director stated he was unaware if additional duct detectors were located in the facility and acknowledged it could not be assured all facility duct detectors were documented as being functional tested annually.</p> <p>3.1-19(b)</p> <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>1. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was clear of blockage once an internal pipe inspection revealed obstruction. NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems at 10-2.3 requires a complete flushing program shall be conducted by qualified personnel. This deficient practice affects all residents, staff and visitors.</p>	K 0062	<p>be submitted to the Quality Assurance Performance Improvement Committee (QAPI) for compliance and any needed intervention.</p> <p>1. What was done to correct the deficient practice for the resident(s) identified?</p> <p>a. The facility has a purchase agreement with SafeCare to flush automatic sprinkler piping system to ensure the system is clear of blockages.</p> <p>b. Contractor installed escutcheon plates on 3 sprinkler heads, rooms 17 and 6</p>	12/20/2015

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	<p>Findings include:</p> <p>Based on review of SafeCare's "Service Call Report" documentation dated 09/10/14 with the Administrator and the Plant Operations Director at 3:15 p.m. on 11/20/15, an internal pipe inspection conducted on 09/10/14 for the facility's sprinkler system stated "Performed Internal Pipe inspection found system to have rust and debris and needs flushed. Recommend systems be flushed. Send Quote for flush". Based on interview at the time of record review, the Administrator and the Plant Operations Director stated sprinkler system flushing had not been performed since SafeCare's internal pipe inspection and acknowledged sprinkler system flushing has not been performed or scheduled on or after 09/10/14.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of over 100 sprinkler heads was maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect 20 residents, staff and visitors in the vicinity of Room 17.</p>		<p>2. How are others identified who would be effected by the deficient practice?</p> <p>a. The facility has a purchase agreement with SafeCare to flush automatic sprinkler piping system to ensure the system is clear of blockages.</p> <p>b. Plant Operations has completed an audit of all escutcheon plates for all sprinklers, two others were found, room 6 and repaired.</p> <p>3. What systemic Changes have been made to ensure the deficient practice does not continue.</p> <p>a. Plant Operations Director or designee will conduct an annual audit of the flushing program of the automatic sprinkler system by qualified personnel.</p> <p>b. Plant Operations Director will conduct a quarterly facility audit of escutcheon plates. Plates will be installed as needed.</p> <p>4. How are you going monitor (audit) to ensure the deficient practice is fixed?</p> <p>a. Plant Operations Director or designee will submit the results of the annual Sprinkler flush audit to the Quality Assurance Performance Improvement (QAPI) Committee for</p>	

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K 0069 SS=D Bldg. 01	<p>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Operations Director from 12:45 p.m. to 3:05 p.m. on 11/20/15, the escutcheon plate was missing for the automatic sprinkler located in the closet for Room 17. Based on interview at the time of observation, the Plant Operations Director acknowledged the escutcheon plate for the aforementioned automatic sprinkler was missing.</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 observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 1998 edition, Section 3-2.6 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease</p>	K 0069	<p>monitoring or any needed follow up.</p> <p>b. Plant Operations Director will submit the results of the quarterly escutcheon plate audit to the Quality Assurance Performance Improvement (QAPI) Committee for monitoring or any needed intervention. Once there has been 2 consecutive months of 100% compliance, audits will be conducted thereafter.</p> <p>1. What was done to correct the deficient practice for the resident(s) identified? a. Drip trays were purchased and installed on 12.01.15 2. How are others identified who would be effected by the deficient practice? a. Plant Operations Director completed an audit for all equipment requiring drips trays and none were found. 3. What systemic Changes have been made to ensure the deficient practice does not continue. a. Dietary Manager will complete a monthly audit to ensure drip trays are in place. Dietary Manger will</p>	12/20/2015

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K 0130 SS=C Bldg. 01	<p>and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect five kitchen staff.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Operations Director from 12:45 p.m. to 3:05 p.m. on 11/20/15, two of two designated locations underneath the kitchen range hood system drip tray were missing an enclosed metal container for grease to drain into. The designated locations for the grease container each had a one inch in diameter hole in the drip tray beneath the system filters and had an affixed bracket for holding a container but no container was present. Based on interview at the time of observation, the Plant Operations Director acknowledged the two designated locations underneath the kitchen range hood system drip tray was missing an enclosed metal container for grease to drain into.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and</p>	K 0130	<p>education dietary staff that drip trays must be in place. 4. How are you going monitor (audit) to ensure the deficient practice is fixed? a. Dietary Manager will complete a monthly audit to ensure drip trays are in place. Results of the audits will be submitted monthly to the Quality Assurance Performance Improvement Committee (QAPI) to monitor for compliance and any needed further intervention. Once there have been two consecutive months on 100 % compliance, then the Dietary Manger will complete an audit quarterly and submit results to QAP</p> <p>1. What was done to correct the deficient practice for the</p>	12/20/2015

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	<p>interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 65 of 75 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Direct Supply TELS "Battery Operated Detectors" documentation with the Plant Operations Director during record review from 9:20 a.m. to 12:05 p.m. on 11/20/15, documentation of an itemized list by location of weekly battery operated smoke detector testing and monthly cleaning for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Plant Operations Director stated the Direct Supply TELS documentation only states weekly functional testing of all detectors and acknowledged documentation of an itemized list by location of weekly battery operated smoke detector testing and monthly cleaning for the most recent twelve month period was not available for review. Based on observation during</p>		<p>resident(s) identified? a. Plant Operations Director or designee conducted an audit of smoke detectors for testing and cleaning. 2. How are others identified who would be effected by the deficient practice? a. Plant Operations Director or designee conducted an audit of smoke detectors for testing and cleaning. 3. What systemic Changes have been made to ensure the deficient practice does not continue. a. Plant Operations Director and designee were educated on conducting a monthly smoke detector audit room by room and will conduct monthly tests and cleaning of the smoke detectors in resident sleeping areas. 4. How are you going monitor (audit) to ensure the deficient practice is fixed? Plant Operations Director or designee will submit results of the monthly audits for the smoke detectors to the Quality Assurance Performance Improvement (QAPI) Committee for monitoring or any needed follow-up</p>	

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	<p>a tour of the facility with the Plant Operations Director from 12:45 p.m. to 3:05 p.m. on 11/20/15, a First Alert Model SA340 battery operated smoke detector was installed in Room 50. Manufacturer's instructions affixed to the back of the battery operated smoke detector stated to "test weekly" and to "gently vacuum or use clean compressed air once per month" to clean the smoke detector. Based on interview at the time of observation, the Plant Operations Director stated the facility has the same model battery operated smoke detector installed in 65 of 75 resident sleeping rooms in the facility and acknowledged an itemized list by location of weekly testing and monthly battery operated smoke detector cleaning documentation for the most recent twelve month period was not available for review.</p> <p>3.1-19(a)</p>			

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K 0144 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 3 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99,</p>	K 0144	<p>1. What was done to correct the deficient practice for the resident(s) identified?</p> <p>a. The Generator Load test is scheduled monthly with TELS. Load tests have been documented April, May, June, July, August, September, October and November.</p> <p>2. How are others identified who would be effected by the deficient practice?</p> <p>a. An Audit was conducted and found generator load tests were completed monthly beginning April 2015 to present.</p> <p>3. What systemic Changes have been made to ensure the deficient practice does not continue.</p> <p>a. Plant Operations Director or designee will submit monthly generator load test to Quality Assurance Performance Improvement Committee (QAPI) to ensure compliance. QAPI Committee will monitor for compliance and will intervene as needed</p>	12/20/2015

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K 9999 Bldg. 01	<p>3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Direct Supply TELS "Logbook Documentation: Emergency Power Generator" with the Plant Operations Director during record review from 9:20 a.m. to 12:05 p.m. on 11/20/15, documentation of monthly load testing for January 2015 through March 2015 was not available for review. Based on interview at the time of record review, the Plant Operations Director acknowledged monthly load testing documentation for January 2015 through March 2015 was not available for review.</p> <p>3.1-19(b)</p> <p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p>	K 9999	<p>4. How are you going monitor (audit) to ensure the deficient practice is fixed?</p> <p>a. Plant Operations Director or designee will submit monthly generator load test to Quality Assurance Performance Improvement Committee (QAPI) to ensure compliance. QAPI Committee will monitor for compliance and intervene as needed</p> <p>1. What was done to correct the deficient practice for the resident(s) identified?</p>	12/20/2015	

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	<p>3.1-19(a) The facility must be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel, and the public.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to continuously provide smoke detectors in 1 of 75 resident sleeping rooms. This deficient practice could affect 20 residents in the facility.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Operations Director from 12:45 p.m. to 3:05 p.m. on 11/20/15, a smoke detector was not observed installed in Room 9 in the Rosewood Hall. Based on interview at the time of observation, the Plant Operations Director stated the resident sleeping room smoke detector in Room 9 had been temporarily removed for painting, painting has been completed and acknowledged a smoke detector was not provided in Room 9.</p> <p>3.1-19(ff)</p>		<p>a. Battery powered smoke detector was installed in room 9 on 11.20.15</p> <p>2. How are others identified who would be effected by the deficient practice?</p> <p>a. The Plant Operations Director completed an audit of the entire facility, found additional rooms which needed battery powered smoke detectors and installed them.</p> <p>3. What systemic Changes have been made to ensure the deficient practice does not continue.</p> <p>a. Plant Operations Director or designee will conduct a monthly audit of battery powered smoke detectors are in each resident room . An</p>	

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			<p>audit tool will be used which is specific to each resident room.</p> <p>4. How are you going monitor (audit) to ensure the deficient practice is fixed?</p> <p>a. Plant Operations Director or designee will submit results of the monthly battery powered smoke detectors located in the resident sleeping rooms to the Quality Assurance Performance Improvement Committee (QAPI) for monitoring and any needed interventions. Monthly audits will continue on an ongoing basis</p>	