

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155738	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
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NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 206 E MARION ST SOUTH BEND, IN 46601
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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: 11/05/15</p> <p>Facility Number: 001141 Provider Number: 155738 AIM Number: 200905640</p> <p>At this Life Safety Code survey, Milton Home 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 two story facility with a basement is fully sprinklered and was determined to be of Type II (111) construction. The original building was constructed in 1952 with the nursing addition located on the first and second floors added in 1975. The facility has a fire alarm system with smoke detection in the corridors, in resident sleeping rooms on the second</p>	K 0000	The Facility shall ensure the following plan of correction meets the requirements of the identified standards.	
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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=D Bldg. 01	<p>floor and in all areas open to the corridor. Resident sleeping rooms on the first floor have battery operated smoke detectors. The facility has a capacity of 34 and had a census of 21 at the time of this survey.</p> <p>Quality Review completed 11/13/15 - 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 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 16 resident room corridor doors closed and latched into the door frame. This deficient practice could affect 2 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 11/05/15 at 2:20 p.m., the Maintenance Director and Housekeeper #1</p>	K 0018	<p>1. The facility shall ensure that all resident room corridor doors close and latch properly.</p> <p>1. Resident room 121 door was adjusted properly, hole filled and latched into the door frame.</p> <p>2. Monthly, the Maintenance director will assess all the resident room doors to ensure all residents doors close and latching into the door frame. These assessments will be documented on an audit form and reviewed with the Administrator.</p>	12/05/2015

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K 0020 SS=E Bldg. 01	<p>acknowledged the corridor door to resident room 121 was not latching into the door frame when tested.</p> <p>3.1-19(b)</p> <p>2. Based on observation, the facility failed to ensure 1 of 16 resident room doors were capable of resisting smoke for at least 1/2 hour. This deficient practice could affect 1 resident.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Housekeeper #1 on 11/05/15 at 12:34 p.m., the corridor resident room door 202 was not smoke resistant due to a half inch hole drilled through. Based on interview at the time of observation, the Maintenance Director and Housekeeper #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating</p>		<p>These assessments will be used ongoing.</p> <p>3.The Maintenance Director will review compliance with the Quality Assurance Committee monthly thereafter.</p>				

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	<p>of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. Based on observation, the facility failed to ensure 1 of 4 stairways had doors that were capable of resisting fire and smoke for at least 1/2 hour. NFPA 101, LSC 2000 Edition, in 8.2.4.3.4 requires doors in smoke barriers to be in accordance with NFPA 80, 1999 Edition, the Standard for Fire Doors and Windows. NFPA 80, Section 2-3.1.7 requires the clearance between the edge of the door and the pull side of the frame not exceed 1/8 inch. This deficient practice affects all staff, clients, and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Housekeeper #1 on 11/05/15 at 1:08 p.m. then again at 3:24 p.m., the second floor entrance double doors were hung up on each other when released leaving a half of an inch gap. Then again, the stairwell by Therapy had a two inch by twelve inch gap with conduit passing through. Based on interview at the time of each observation, the Maintenance Director and Housekeeper #1 acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>	K 0020	<p>1.The Facility will ensure that it meets the requirements for NFPA 101 8.2.4.3.4.</p> <p>2.The Maintenance Director removed one of the glass blocks and took it to Old Fort Building Supply in South Bend. They supply commercial glass blocks and stone. The glass block was measured and identified as a 4 inch commercial grade, withstanding a 1 hour fire rating. The specifications for the glass block is attached.</p> <p>3.The facility will ensure that any new construction all materials have fire rating and records are keep.</p> <p>4.The Maintenance Director will report findings to the QA&A committee for any new recommendations.</p>	12/05/2015			

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K 0021 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 4 vertical openings were enclosed with construction having at least a one hour fire resistance. LSC 19.3.1.1 requires any vertical opening to be enclosed or protected in accordance with LSC 8.2.5. LSC 8.2.5.4 refers to 7.1.3.2.1 for enclosure of exits. LSC 7.1.3.2.1 requires openings in the separation be protected by fire door assemblies equipped with door closers complying with 7.2.1.8. NFPA 80, the Standard for Fire Doors and Fire Windows at 2-1.2 requires fire door assemblies to include latches. NFPA 80, 2-1.4 requires fire doors to be closed and</p>	K 0021	<p>1. The facility shall ensure all the vertical openings are enclosed with construction at least one hour fire resistance. The facility will also ensure that all doors requiring door closer are installed and operate correctly. The facility will ensure that all doors that are required to latch operates correctly. The facility will ensure that fire doors close simultaneously and latch.</p> <p>2. a) the entrance stairwell fire doors were adjusted to close and latch properly. b) the stairwell door by room 207 was adjusted and shut properly. Door was also inspected and fire rating tag was applied. c) stairwell</p>	12/05/2015
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	<p>latched at the time of fire. This deficient practice could affect staff, visitors, and all 21 residents because the stairwell doors that failed to latch where on each side of the fire barrier on both floors with resident access.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Housekeeper #1 on 11/05/15 between 1:08 p.m. and 3:24 p.m., the following was discovered:</p> <p>a) the entrance stairwell double doors failed to latch when tested on the first and second floor when tested.</p> <p>b) the stairwell door by resident room 207 failed to self close and latch when tested. Also, the door did not have a rating tag.</p> <p>c) the stairwell doors by the Kitchen failed to self close and latch when tested.</p> <p>d) the stairwell door by "The Apartment" entering the stairwell was missing. The door in the Stairwell leading to "The Apartment" did not have a label rating.</p> <p>e) one of the two stairwell doors by Therapy did not have a label rating.</p> <p>Based on interview at the time of each observation, the Maintenance Director and Housekeeper #1 acknowledged each of the aforementioned condition and provided the measurement.</p>		<p>door next to the kitchen was adjusted to self close and latch.</p> <p>d) stairwell door next to apartment was installed with approved fire rated door.e) all other doors with no fire rated tags were inspected and tag applied.</p> <p>1.The Maintenance director will use audit tool " Life Safety Inspection" to ensure compliance.</p> <p>2.The Maintenance Director will review report to QA&A meeting monthly for compliance.</p>				

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K 0022 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4</p> <p>1. Based on observation, the facility failed to ensure 1 of 1 1st floor Center Stairwell exit discharge paths was marked with directional indicators to make the direction of travel to reach the public way obvious. LSC 7.10.2 requires a sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. This deficient practice could affect staff and at least 16 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Housekeeper #1 on 11/05/15 at 3:52 p.m., the 1st floor Center Stairwell door had an exit sign on the door and an illuminated exit sign above the door. The exit would direct one's path directly to the lower level exit to the outside. The lower level exit door said not an exit. Based on an interview at the time of observation, the Maintenance</p>	K 0022	<p>1.The facility shall ensure exits are properly marked.</p> <p>2.The lower level exit door leading to the outside was changed from "not an exit" to an "exit". Sun porch exit signs were changed from "not an exit" to an "exit".</p> <p>3.The Maintenance Director will use audit tool "life Safety Inspection" to ensure compliance.</p> <p>4.Maintenance Director will report findings to the QA&A team monthly.</p>	12/05/2015			

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	<p>Director and Housekeeper #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 set of doors likely to be mistaken for a way of exit from the Sitting Room was identified as "No Exit". LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads: NO Exit. This deficient practice could affect up to 15 residents would be in the Sitting Room or Sun Porch.</p> <p>Findings include: Based on observation with the Maintenance Director and Housekeeper #1 on 11/05/15 at 1:53 p.m., the door leading to the Sitting Room or Sun Porch contained an exit sign with arrows pointing toward the Sitting Room. The Sitting Room opens up to the Sun Porch, which contains two separate exit doors labeled not an exit. Based on interview at the time of observation, the Maintenance Director and Housekeeper #1</p>			

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K 0025 SS=D Bldg. 01	<p>acknowledged the aforementioned condition. 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 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 1 of 1 ceiling smoke barriers and 1 of 6 smoke barrier corridor walls were maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect staff and up to 19 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Housekeeper #1 on 11/05/15 from 12:41 p.m. to 3:58 p.m., the following unsealed smoke</p>	K 0025	<p>1.The facility shall ensure smoke barriers are provided of at least one half hour fire resistance.</p> <p>2.The Maintenance Director completed protecting all unsealed smoke barrier corridor wall penetration and replaced all missing ceiling tiles.</p> <p>3.Maintenance Director will assess the facility for the deficient practices monthly and will report to Administrator any findings until compliance.</p> <p>4.The Maintenance Director will report to QA&A monthly for compliance.</p>	12/05/2015			

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	<p>barrier corridor wall penetration and unsealed ceiling penetrations were noted:</p> <p>a) three quarter inch floor gap around sprinkler pipe in the Roof Access room</p> <p>b) a quarter inch ceiling gap around sprinkler pipe in the corridor by resident room 208</p> <p>c) a quarter inch ceiling gap around sprinkler pipe in the Front Desk office</p> <p>d) four out of ten ceiling tiles missing in the Elevator room</p> <p>e) five separate corridor wall penetrations ranging from a quarter inch to three quarter inch by Medical Records office.</p> <p>f) twenty five ceiling penetrations ranging from a quarter of an inch by six and a quarter square inch in the Basement Boiler room.</p> <p>g) a two and a half inch by two and a half inch ceiling penetration in the Maintenance office.</p> <p>h) six out of twenty four ceiling tiles were missing in the Paint room.</p> <p>i) one out of nine ceiling tiles were missing the in the oxygen storage room.</p> <p>j) four ceiling penetrations ranging from three quarter inch to two and a half inch in the Laundry room.</p> <p>Based on interview at the time of each observation, the Maintenance Director and Housekeeper #1 acknowledged and provided the measurements for each unsealed penetration.</p>			

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K 0029 SS=E Bldg. 01	<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 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 the 1 of 2 corridor doors to the kitchen and 1 of 1 Boiler room, both hazardous areas, was provided with self closer and would latch into the frame. This deficient practice could affect staff and at lest 23 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Housekeeper #1 on 11/05/15 at 2:00 p.m. then again 3:12 p.m., one of the two kitchen doors failed to latch when tested. Then again the Boiler room door caught on the ground and failed to self close and positively latch in the frame. Based on</p>	K 0029	<p>1.The Facility shall ensure that all self closing doors will shut and latch into the frame. Facility will also ensure that storage areas have doors that close without hesitation.</p> <p>2.Kitchen door was adjusted and self closer was applied. Boiler room door was adjusted and now shuts properly.</p> <p>3.Maintenance Supervisor will use QA tool for compliance.</p> <p>4.Maintenance Director will report findings to the QA&A committee ongoing.</p>	12/05/2015

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	<p>interview at the time of each observation, the Maintenance Director and Housekeeper #1 acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 Basement Classroom, 1 of 1 Nursing Supply, and 1 of 1 Activities, such as a combustible storage area over 50 square feet in size, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect staff and up to 8 residents who might be using the Salon or Therapy in the basement.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Housekeeper #1 on 11/05/15 between 2:43 p.m. and 2:32 p.m., the following was discovered:</p> <p>a) the Basement Classroom had a storage area open to it without a door. Inside the storage area contained nine mattresses and other clean linen. The Basement class room was also open to the basement corridor.</p> <p>b) Nursing Supply contained two wooded pallets, about seventy cardboard boxes, two chairs. The door to Nursing Supply</p>			

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K 0038 SS=E Bldg. 01	<p>did not have a self closer. Based on interview at the time of each observation, the Maintenance Director and Housekeeper #1 acknowledged the aforementioned condition.</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 exit access was arranged so 1 of 4 exits were readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1 requires the means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. In addition to providing the required width to allow all occupants safe access to a public way, such access also needs to meet the requirements with respect to maintaining the means of egress free of obstructions that would prevent its use, such as snow and the need for its removal in some climates or soft ground during heavy</p>	K 0038	<p>1.The Facility will ensure that all exits from the building have a safe access and a means of egress.</p> <p>2.Weather permitting the Maintenance Director will pour cement to a safe egress</p> <p>3.QA tool will be used for compliance.</p> <p>4.Maintenance Director will report to QA&A committee monthly.</p>	12/05/2015

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K 0050 SS=C Bldg. 01	<p>periods of rain. This deficient practice could affects staff, visitors, and at least 8 residents on the first floor and 6 on the second floor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Housekeeper #1 on 11/05/15 at 12:20 p.m., the exterior exit door by resident room 106 discharged 26 inches of cement which then continues to woodchips then grass. The next closest cement pad is eleven feet away. Based on interview at the time observation, the Maintenance Director and Housekeeper #1 acknowledged the aforementioned condition and provided the measurements.</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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	<p>Based on record review and interview, the facility failed to ensure 8 of 8 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" with the Maintenance Director and Housekeeper #1 on 11/05/15 at 10:51 a.m., the documentation for the drills performed between the hours of 6:00 a.m. and 9:00 p.m. for the past twelve months lacked verification of the transmission of the signal for drills. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition and confirmed he was only including the time he called the monitoring station.</p> <p>3.1-19(b) 3.1-51(c)</p>	K 0050	<p>1.The Facility will ensure that fire drills are preformed with monitoring system that there is a record of verification of transmission of the fire alarm signal.</p> <p>2.Maintenance Director will ensure that between the hours of 6am-9pm fire alarm monitoring system will have verification of transmission.</p> <p>3.Maintenance Director will use the fire drill report for compliance.</p> <p>4.Maintenance Director will report to the QA&A committee monthly.</p>	12/05/2015	

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K 0052 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is 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 and interview, the facility failed to ensure 1 of 43 smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following</p>	K 0052	<ol style="list-style-type: none"> 1.The Facility will ensure that all the smoke detectors are in compliance with NFPA 72, 7-3.2. 2.Maintenance Director will have Koorsen re-calibrate the smoke detector and if bad re-place smoke detector. 3.Maintenance Director will review with vendors on exit that facility is in compliance with fire codes after all inspections. 4.Maintenance Director will report monthly to the QA&A committee for compliance. 	12/05/2015

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	<p>methods:</p> <p>(1) Calibrated test method</p> <p>(2) Manufacturer's calibrated sensitivity test instrument</p> <p>(3) Listed control equipment arranged for the purpose</p> <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</p> <p>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director and Housekeeper #1 on 11/05/15 at 11:10 a.m., the most recent documentation of a smoke detector sensitivity test was completed by Koorsen dated 05/13/15. The Front Office smoke detector was listed with a range of 2.1-3.22. The Front Office smoke detector provided a tested value of 1.8. Based on an interview at the time of record review, the Maintenance Director and Housekeeper #1 acknowledged the</p>						

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K 0062 SS=D Bldg. 01	<p>aforementioned condition and was unable to provide any other documentation.</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 observation and interview, the facility failed to ensure 1 of 1 bathroom sprinkler heads in resident room 210 was maintained. This deficient practice could affect 1 resident.</p> <p>Findings include:</p> <p>Based on observations the Maintenance Director and Housekeeper #1 on 11/05/15 at 12:47 p.m., resident room 210 was missing one escutcheon in the resident room bathroom. Based on interview at the time of observation, the Maintenance Director and Housekeeper #1 acknowledged the missing escutcheon at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 1 of 1 painted</p>	K 0062	<p>1.The Facilitywill ensure that automatic sprinkler systems are maintained and areinspected, clear of any obstructions.</p> <p>2.MaintenanceDirector applied escutcheon in room 210. Resident room 208 thesprinkler head was cleaned and clear of obstructions.</p> <p>3.Life Safetyinspection QA tool will be used for compliance.</p> <p>4.Monthly theMaintenance Director will report to QA&A Committee forcompliance.</p>	12/05/2015

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K 0064 SS=E Bldg. 01	<p>sprinkler heads in Resident Room 208 Bathroom. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected 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 1 resident.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Housekeeper #1 on 11/05/15 at 12:50 p.m., resident room 208 bathroom sprinkler head was covered in paint. Based on interview at the time of observation, the Maintenance Director and Housekeeper #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all</p>			

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	<p>health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 3 portable fire extinguishers in the West Wing were installed correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect staff and at least 16 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Housekeeper #1 on 011/05/15 at 2:10 p.m., the fire extinguisher in the West Wing measured 66 inches from the top of the extinguisher to the floor. Based on interview at the time of observation, the Maintenance Director and Housekeeper #1 acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 Beauty</p>	K 0064	<p>1.The facility will ensure that portable fire extinguisher are mounted to the NFPA10 code. Also the facility will ensure that all the fire extinguishers have test per code. Have been examined and recorded by the Maintained department.</p> <p>2.Fire extinguisher in the wast wing was mounted to per the code. The fire extinguisher in the beauty shop was replaced. Fire extinguisher in the kitchen was inspected by the provider and maintenance wil preform monthly checks.</p> <p>3.Life Safety inspection QA tool will be used for compliance.</p> <p>4.Maintenance Director will report to QA&A monthly for compliance.</p>	12/05/2015			

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	<p>Shop fire extinguishers requiring a 12-year hydrostatic test was emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect staff and up to 3 residents.</p> <p>Findings include:</p> <p>Based on observation and interview with the Maintenance Director and Housekeeper #1 on 11/05/15 at 3:03 p.m., the printed date on the fire extinguisher indicated the last six year test was completed 11/2008.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to inspect 1 of 1 portable type K fire extinguishers in the Kitchen 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</p>			
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K 0070 SS=D Bldg. 01	<p>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 staff only.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director and Housekeeper #1 on 11/05/15 at 1:58 p.m., the monthly inspection tag on the fire extinguisher located in the Kitchen indicated the lack of a monthly inspection for the months of August, September, and October of 2015. Based on interview at the time of observation, the Maintenance Director and Housekeeper #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation, interview, and record review, the facility failed to enforce the policy for the use of 1 of 1 portable space heaters in accordance with NFPA 101, Section 19.7.8. This</p>	K 0070	<p>1.The Facility will ensure that all portable space heaters are not used per the NFPA 101</p> <p>2.Maintenance director removed all the space heaters.</p>	12/05/2015

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K 0076 SS=D Bldg. 01	<p>deficient practice could affect staff.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director and Housekeeper #1 on 11/05/15 between 10:14 a.m. and 12:30 p.m., the space heater policy states the facility does not allow space heaters. Based on observation with the Maintenance Director and Housekeeping at 2:57 p.m., a space heaters was discovered in the Basement "Apartment." Based on interview at the time of observation, the Maintenance Director and Housekeeper #1 acknowledged the space heaters was a violation of the facility's policy.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>1. Based on observation and interview,</p>	K 0076	<p>3.Maintenance director will us Life Safety inspection tool for compliance.</p> <p>4.QA tool will be review by QA&A committee for compliance monthly.</p>			12/05/2015	

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	<p>the facility failed to ensure 1 of 1 cylinders of nonflammable gases was properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Housekeeper #1 on 11/05/15 at 1:14 p.m., one oxygen cylinder was discovered unsupported in the Front Desk. Based on interview at the time of observation, the Maintenance Director and Housekeeper #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical outlets in the oxygen storage room in the basement was located at least five feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage</p>		<p>1. The Facility will ensure that Oxygen is being stored properly and the room is to the NFPA 99 code.</p> <p>2. Staff was in-serviced for storage of Oxygen cylinders. Light switch in the storage was moved per state code.</p> <p>3. All managers will monitor for compliance.</p> <p>4. QA&A team will discuss monthly for compliance.</p>				

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K 0144 SS=C Bldg. 01	<p>locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Housekeeper #1 on 11/05/15 at 3:53 p.m., there is one electrical switch on the wall in the basement oxygen storage room. The one electrical switch was forty six inches above the floor. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p> <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. 1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load</p>	K 0144	1.The Facility will ensure that it meets the requirements for Life Safety code NFPA99	12/05/2015			

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	<p>testing for 1 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on record review of the generator log "Monthly Generator Full Load Test" with the Maintenance Director and Housekeeper #1 on 11/05/15 at 11:47 a.m., there was no documentation of a generator load test for the month of October 2015. Based on interview at the time of record review, the Maintenance Director and Housekeeper #1 acknowledged the aforementioned</p>		<p>2.The Maintenance Director has been in-serviced by Herman and Getz on how to maintain the Generator.</p> <p>3.Maintenance Director will use Life Safety Inspection form for compliance.</p> <p>4.Maintenance Director will report to QA&A monthly for compliance.</p>				

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	<p>condition.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections of the starting batteries for the generator was maintained for 20 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview and review of generator documentation on 11/05/15 at</p>						

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K 0147 SS=E Bldg. 01	<p>11:47 a.m. with the Maintenance Director and Housekeeper #1, the weekly generator inspections were not documented after 06/01/2015.</p> <p>3.1-19(b)</p> <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>1. Based on observation and interview, the facility failed to ensure 1 of 1 multiplug adapters and 18 of 18 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 12 residents.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Director and Housekeeper #1 on 11/05/15 between 12:32 p.m. to 2:44 p.m. the following was discovered: a) a surge protector was powering an air conditioner in resident room 215.</p>	K 0147	<p>1.The Facility will ensure that it meets the requirements for Life Safety Code NFPA70 National Electric Code.</p> <p>2.Room 215,214, Social Service office, room 213, room 210, room 208, 205, Front Desk, surge protector's were removed. Room 106, Elevator room,conference room, extension cords were remove. Outlet in the roof access and MDS office cover was applied.</p> <p>3.Maintenance Director will use Life Safety Inspection form for compliance.</p> <p>4.Maintenance Director will report to QA&A monthly for compliance.</p>	12/05/2015

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	<p>b) a surge protector was powering an air conditioner in resident room 214.</p> <p>c) a surge protector was powering an air conditioner and a refrigerator in the Social Services office.</p> <p>d) an extension cord was powering a surge protector powering a home phone and cell phone charger in resident room 213. Also, an extension cord powering a call light.</p> <p>e) a surge protector was powering a microwave in Resident room 210. Also, a multiplug adapter powering television components.</p> <p>f) a surge protector was powering an air conditioner in resident room 208.</p> <p>g) a surge protector was powering an air conditioner in resident room 205.</p> <p>h) a surge protector was powering another surge protector powering a router in the Front Desk office.</p> <p>i) an extension cord was powering a cell phone charger in resident room 106. Also, an extension cord was powering a microwave. Also, an extension cord was powering a refrigerator.</p> <p>j) an extension cord powering phone components in the Elevator room.</p> <p>k) an extension cord powering another extension cord powering a surge protector powering television in the Conference room open to the basement corridor.</p> <p>Based on interview at the time of each</p>			

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	<p>observation, the Maintenance Director and Housekeeper #1 acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain an electrical outlet in 1 of 1 Roof Access room and 1 of 1 MDS office. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Housekeeping on 11/05/15 at 2:41 p.m. then again 3:05 p.m., an outlet switch was missing a cover in the Roof Access room. Then again an outlet cover was missing in the MDS office. Based on interview at the time of each observation, the Maintenance Director and Housekeeper #1 acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>			

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K 0154 SS=C Bldg. 01	<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 ensure its written fire watch policy addressed all procedures to be followed in this facility in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. in order to protect 21 of 21 residents. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview with the Maintenance Director and Housekeeper #1 on 11/05/15 at 10:31 a.m., the facility did have a written fire watch policy and procedure for a automatic sprinkler system failure but it did not address all components of LSC Section 9.6.1.8. Specifically, the plan did not state the person conducting the fire watch shall be assigned no other duties during that time.</p>	K 0154	<p>1.The Facility will ensure that it has an approved fire watch system in place during and outage of the Sprinkler system for more than 4 hours in a24 hour period.</p> <p>2.Maintenance Director and Housekeeper #1 was in-serviced on the plan where 1person would be identified and have assigned no other job duties.</p> <p>3.Maintenance Director and Housekeeper #1 will in service staff of the policy.</p> <p>4.Maintenance Director will report to QA&A monthly for compliance.</p>	12/05/2015			

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K 0155 SS=C Bldg. 01	<p>3.1-19(b)</p> <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 ensure its written fire watch policy addressed all procedures to be followed in this facility in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. in order to protect 21 of 21 residents. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview with the Maintenance Director and Housekeeper #1 on 11/05/15 at 10:31 a.m., the facility did have a written fire watch policy and procedure for a fire alarm system failure but it did not address all components of LSC Section</p>	K 0155	<p>1.The Facility will ensure that it has an approved fire watch system in place during an outage of the Fire Alarm System for more than 4hours in a 24 hour period.</p> <p>2.Maintenance Director and Housekeeper #1 was in-serviced on the plan where 1person would be identified and have assigned no other job duties.</p> <p>3.Maintenance Director and Housekeeper #1 will in-service staff of the policy.</p> <p>4.Maintenance Director will report to QA&A monthly for compliance.</p>	12/05/2015

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K 0160 SS=D Bldg. 01	<p>9.6.1.8. Specifically, the plan did not state the person conducting the fire watch shall be assigned no other duties during that time.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observation and interview; the facility failed to ensure 1 of 1 elevator equipment rooms was provided with an electrical shunt trip when provided with sprinkler coverage. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice would affect staff only.</p>	K 0160	<p>1. The Facility will ensure that it meets the requirements of NFPA 13.5-13.6.2.2. The Maintenance Director has called an Electrician to install a shunt trip for the elevator machine room.3. Maintenance Director will ensure compliance and the repair has been completed.4. The Maintenance Director will report th QA&A for compliance monthly for 3 months.</p>	12/05/2015			

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director and Housekeeper #1 on 11/05/15 at 2:36 p.m., the elevator equipment room contained 1 sprinkler head. Based on interview at the time of observation, the Maintenance Director and Housekeeper #1 was unable to confirm the elevator equipment was provided with an elevator shunt trip, and acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>				