STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 01 B. WING	02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	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). Survey Date: 02/10/16 Facility Number: 000538 Provider Number: 155620 AIM Number: 100267290 At this Life Safety Code survey, Zionsville Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility is a split level facility with each of the two floors exiting at ground level was determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	system in all resident sleeping rooms. The facility has a capacity of 185 and had a census of 135 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered. Quality Review on 02/15/16 by Lex Brashear, LSC Specialist			
K 0017 SS=E Bldg. 01	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 1. Based on observation and interview, the facility failed to provide corridor wall separation in 1 of over 125 rooms. This deficient practice could affect 25 residents, staff and visitors in the vicinity of the Housekeeping Closet by Room 154.	K 0017	**What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?** **1.** 1.The five inch by five inch square hole in thecorridor wall above the Housekeeping closet	03/11/2016

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	Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 02/10/16, a five inch by five inch square hole was in the corridor wall above the door to the Housekeeping Closet by Room 154. A freestanding loose fire damper was placed inside the square hole and was not affixed to the wall in the hole. Two screws partially affixed a metal plate to cover the hole on the room side of the wall but a one half inch gap was noted on the sides and top of the plate which was not smoke resistant and failed to separate the room from the corridor. No fire alarm system smoke detector was noted inside the Housekeeping Closet. Based on interview at the time of the observation, the Maintenance Supervisor acknowledged the aforementioned hole in the wall failed to separate the Housekeeping Closet from the corridor. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 corridors open to the Villa Dining Room area was provided with an electrically supervised automatic smoke detection		by room 154 has been closed andrepaired. 2.The freestanding loose fire damper place insidethe square hole has been affixed and secured to the wall. 3.The half inch gap noted on the sides of themetal plate to cover the hole on the room side of the wall has been repaired andfire caulked to separate the room from the corridor. 4.A smoke detector has been installed in thehousekeeping closet. 1.The installation of positive latching device oneach leaf of the door sets of Villa Dining room and installation ofelectrically supervised automatic smoke detection system will correct thedeficient. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken:** Approximately 25 residents, staff and visitors in thevicinity of the HK closet by Room154 have potential to be affected. The 10residents, staff or visitors in the vicinity of the Villa Dining room havepotential to be affected. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** The Maintenance Director/Designee	

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	system. Exception No. 1 to LSC Section 19.3.6.1 states smoke compartments protected throughout by an approved, 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: (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. This deficient practice could affect 10 residents, staff or visitors in the vicinity of the Villa Dining Room. Findings include: Based on observations with the		will be in serviced toensure all repairs meet the fire criteria and safety of residents. **How the correctiveactions will be monitored to ensure the deficient practice will not recur, i.e.what quality assurance program will be put into place:** The Maintenance Director/Designee will do a monthly checksand submit the results during Quality Assurance Committee for review andcompliance.	

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	Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 02/10/16, the Villa Dining Room near the Assisted Living (AL) Lounge and Chapel was open to the corridor because the Villa Dining Room area was open to main lobby corridor. A double door set at the entrance to the Villa Dining Room from the Lounge was not provided with a positive latching device on each leaf in the door set. The Villa Dining Room area is not provided with an electrically supervised automatic smoke detection system. The automatic sprinkler system observed in the Villa Dining Room 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 Maintenance Supervisor stated comprehensive care residents have customary access to the main lobby and AL Lounge and acknowledged the Villa Dining Room area is open to the corridor and is not provided with an electrically supervised automatic smoke detection system. 3.1-19(b)			
K 0018 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical			

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	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 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of over 125 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 30 residents, staff and visitors in the vicinity of the breakroom by the B Wing nurses station. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 02/10/16, the corridor door to the breakroom by the B Wing nurses station was propped open with a chair and had paper sign taped to the door stating "Don't shut the door or you'll get locked in." The door handle included a keypad to enter a code to release the door handle	K 0018	**What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice:** The door handle with keypad was repaired and workingproperly allowing the door to shut securely and open by utilizing the key pad.The sign was removed. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken:** Employees and visitors have potential to be affected. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** All staff will be in serviced on not keeping doors proppedopen and keeping doors securely closed. **How the correctiveactions will be monitored to ensure the**	02/10/2016

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	but the keypad was partially dismantled. Based on interview at the time of observation, the Maintenance Supervisor stated a work order had not been filed to repair the door handle keypad, the keypad needed a battery installed to ensure proper operation of the door handle and acknowledged the aforementioned corridor door had an impediment to closing and latching into the door frame. 3.1-19(b)		**deficient practice will not recur, i.e.what quality assurance program will be put into place:** Maintenance/Designee will review and process the work orders on-going basis and address the items needed for repair. The completed workorders will be submitted to the Quality Assurance Committee for review.	
K 0021 SS=D Bldg. 01	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: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 5 kitchen exit doors was held open only by a device arranged to automatically close upon activation of the fire alarm system. This deficient practice could affect 5 staff in the kitchen.	K 0021	**What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?** The wedge used to keep the door open in the storage room inthe kitchen was immediately removed during survey which would allow the door full	02/10/2016

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	Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 02/10/16, the door in the storage room in the kitchen was held in the fully open position with a wedge on the floor. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned door was propped open with a wedge and would fail to allow full closure automatically upon activation of the fire alarm system. 3.1-19(b)		closureautomatically upon activation of the fire alarm system **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken:** All residents and staff have the potential to be affected. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** All dietary staff will be in service on not propping doorsopen. **How the corrective actions will be monitoredto ensure the deficient practice will not recur, i.e. what quality assuranceprogram will be put into place:** Dietary Manager/Designee will monitor the door dailyensuring that the door is securely closed.	
K 0025 SS=D Bldg. 01	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 Based on observation and interview, the	K 0025	**What correctiveactions will be accomplished for those residents**	03/11/2016

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	facility failed to ensure openings through 1 of 2 ceiling smoke barriers were protected to maintain the fire resistance rating of the smoke barrier. 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 5 staff and visitors in the Main Office area. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 02/10/16, an eight inch by four inch hole for the passage of twenty cables was noted in the ceiling of the computer room in the Main Office area. In addition, the one inch annular space surrounding each of three, three inch in diameter pipes which penetrated the ceiling of the computer room were not filled with a material capable of maintaining the smoke resistance of the smoke barrier. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the aforementioned holes in the computer room ceiling failed to		**found to have been affected bythe deficient practice?** The eight inch by four inch hole noted in the ceiling of thecomputer room in the Main Office will be repaired with fire pillow material tomeet the ½ hour fire rating. The one inch annular space surrounding each of the three,three inch in diameter pipes which penetrated the ceiling of the computer room will be repaired with fire pillows capable of maintaining the ½ hour fire ratingcapable of maintaining the smoke resistance of the smoke barrier. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken:** The office staff, residents and visitors could havepotential to be affected. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** Maintenance/Designee will audit, inspect and identify anyannular space and will fill them with material capable of smoke resistance. **How the correctiveactions will be monitored to ensure the deficient practice will not recur, i.e.what quality assurance program will be put into place:** Maintenance/Designee will report all results related to thefire/smoke	

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	maintain at least a one half hour fire resistance rating for the ceiling smoke barrier. 3.1-19(b)		barrier audits to the Quality Assurance Committee	
K 0027 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 2 lower level sets of smoke barrier doors would close to form a smoke resistant barrier. Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors which swing in the same direction and equipped with an astragal to have a coordinator to ensure the door which must close first always closes first. This deficient practice could affect 10 residents, staff and visitors in the lower level memory care area lobby by the Cottage 2 Nurses' Station. Findings include: Based on observation with the	K 0027	**What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?** The smoke barrier doors in the corridor in the lower levelmemory care area by the Cottage 2 Nurse's station will be repaired withappropriate door closing coordinators to maintain the fire resistant barrier. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken:** Visitor, residents and employees have potential to beaffected. **What measures will beput into place or what systemic changes will be made to ensure that**	03/11/2016

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	Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 02/10/16, the set of smoke barrier doors in the corridor in the lower level memory care area lobby by the Cottage 2 Nurses' Station swing in the same direction, are equipped with an astragal and a door closing coordinator but the door closing coordinator did not function when the smoke barrier door set was manually closed five times which did not ensure the door equipped with an astragal closes last and forms a smoke resistant barrier. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned smoke barrier door set did not close because the door closing coordinator did not function and was prevented from closing and forming a smoke resistant barrier. 3.1-19(b)		**thedeficient practice does not recur:** Maintenance Director/Designee will inspect and audit all self-closingdevices on the doors. **How the correctiveactions will be monitored to ensure the deficient practice will not recur, i.e.what quality assurance program will be put into place:** The Maintenance Director/Designee will inspect doors as partof their daily rounds. Results of changes or repairs to door closures orcoordinators will be reported to the Quality Assurance Committee.	
K 0029 SS=E Bldg. 01	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			

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	permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 4 of 14 hazardous areas such as fuel fired heater rooms, combustible storage rooms greater than 50 square feet in size, laundries greater than 100 square feet in size and soiled linen rooms were separated from other spaces by smoke resistant partitions and doors. Doors to hazardous areas are self closing or close automatically upon activation of the fire alarm system. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the B Wing Housekeeping Room by the oxygen transfilling and storage room. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 02/10/16, the following was noted: a. the corridor door to the B Wing Housekeeping Room by the oxygen transfilling room was equipped with a self closing device but the door failed to fully close and did not latch into the door frame after five attempts. The Housekeeping Room consisted of two rooms, one measuring 100 square feet and a back room for combustible supply storage which measured 350 square feet. b. the corridor door to the soiled linen	K 0029	**What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?** 1.The self-closing device and the latchingmechanism to the door frame to the B wing Housekeeping room by the oxygentransfilling room will be repaired. 2. Theself-closing device by the corridor door to the soiled linen room side of theLaundry in the service hall will be repaired. 3.The missing ceiling tiles in the Laundry behindthe fuel fired dryers will be replaced to separate this hazardous area roomfrom other spaces with smoke resistance partitions. 4.The seven missing ceiling tiles missing in theCentral Supply Room near the service hall will bereplaced to separate thishazardous area room from other spaces with smoke resistant partitions. 5.The missing ceiling tile in the soiled linenroom by the B-wing Nurse's station will be replaced to separate this hazardousarea room from other spaces with smoke resistant partitions. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken:** Visitor, residents and employees have potential to beaffected.	03/11/2016

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	room side of the Laundry in the service hall was equipped with a self closing device but the door failed to fully close and did not latch into the door frame after five attempts. c. one and a half ceiling tiles were missing in the Laundry behind the fuel fired dryers which failed to separate this hazardous area room from other spaces with smoke resistant partitions. d. seven ceiling tiles were missing in the Central Supply Room near the service hall which failed to separate this hazardous area room from other spaces with smoke resistant partitions. The Central Supply Room contained fuel fired heating equipment. e. one ceiling tile was missing in the soiled linen room by the B Wing Nurse's Station which failed to separate this hazardous area room from other spaces with smoke resistant partitions. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the aforementioned hazardous rooms failed to separate these areas from other spaces by smoke resistant partitions and doors 3.1-19(b)		**What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** Maintenance Director/Designee will conduct facility wideinspection of ALL doors with self-closing devices and areas with missingceiling tiles and immediately correct the areas of concern. **How the correctiveactions will be monitored to ensure the deficient practice will not recur, i.e.what quality assurance program will be put into place:** Maintenance Director/Designee will submit the inspectionfindings to the Quality Assurance Committee for review and compliance.	
K 0046 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.			

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	19.2.9.1. Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 1 of 2 battery powered lights for the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hr duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect 10 residents, staff and visitors in the lower level memory care area lobby by Exit 18. Findings include: Based on review of "Weekly Generator Inspection Sheet" documentation with the Maintenance Supervisor during record review from 9:15 a.m. to 12:15 p.m. on 02/10/16, documentation of monthly functional testing and annual testing for not less than 1 ½ -hr duration for one of two facility battery powered emergency lights for the most recent twelve month	K 0046	**What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?** The Maintenance Director conducted test of allbattery powered emergency lights in the facility for the month and alsocompleted the 1 ½ hour duration testing for the most recent twelve monthperiod. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken:** All residents have potential to be affected. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** Maintenance Director/Designee will create a monitoring tooland utilize it for periodic testing of emergency lighting equipment for every30 days intervals for 30 seconds and create second monitoring tool for the annual 1 ½ hour tests. **How the correctiveactions will be monitored to ensure the deficient practice will not recur, i.e.what quality assurance program will be put into place:** Maintenance Director/Designee will submit the results to theQuality Assurance Committee for review.	03/11/2016

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	period was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated the facility has a total of two battery powered emergency lights in the facility, one at the emergency generator and one in the memory care area. Only the emergency generator light location is documented as monthly and annually tested on the aforementioned weekly generator inspection sheet. The Maintenance Supervisor acknowledged additional battery powered emergency light testing documentation was not available for review. Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 02/10/16, a total of two battery powered emergency lights were noted in the facility and each battery powered emergency light operated when its respective test button was depressed. One battery powered emergency light was located at the emergency generator and the second battery powered emergency light for the facility was located in the lower level memory care area lobby by Exit 18. Based on interview at the time of observation, the Maintenance Supervisor acknowledged documentation of monthly functional testing and annual testing for not less than 1 ½ -hr duration for the most recent twelve month period for the			

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	battery powered emergency light located in the lower level memory care area lobby by Exit 18 was not available for review. 3.1-19(b)			
K 0047 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to ensure 1 of 2 doors likely to be mistaken for a way of exit was identified with a sign reading, No exit. LSC 7.10.8.1 requires any door that is neither an exit or a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall be identified by a sign that reads: NO exit. This deficient practice could affect 15 residents, staff and visitors in the Moving Forward Lounge next to the Social Services Office. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 02/10/16, the Moving Forward Lounge door which leads to the outside of the building is not marked with a	K 0047	**What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?** A "NO EXIT" sign has been posted by the locked door inmoving forward lounge next to social service office. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken:** All residents have the potential to be affected. **What measures will be put into place or what systemic changes will bemade to ensure that the deficient practice does not recur:** The Maintenance Director/Designee will inspect and identifyany doors that is neither an exit nor a way of exit access which can bemistaken for and exit during monthly checks ensuring that the doors have NOEXIT signs in place. **How the correctiveactions will be**	03/11/2016

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	facility exit sign. The door was locked and was not equipped with a sign stating "NO exit." Based on interview at the time of observation, the Maintenance Supervisor stated the aforementioned door which leads to the outside of the building is not a facility exit and acknowledged it was not equipped with a sign stating, "NO exit." 3.1-19(b)		**monitored to ensure the deficient practice will not recur, i.e.what quality assurance program will be put into place:** All results will be submitted to the Quality AssuranceCommittee.	
K 0048 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to document a complete written health care occupancy fire safety plan for 1 of 1 plans which incorporated all items listed in NFPA 101, Section 19.7.2.2. (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 This deficient practice affects all residents, staff and visitors in the event of	K 0048	**What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?** The Disaster Preparedness Plan will be updated to identifythe locations of the smoke barrier doors and the fire doors in the facility forthe evacuation of the smoke compartments, also the diagram for the evacuationprocedures for Section A will be updated to identify the location of the smokeand fire barrier doors. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken:** All residents have potential to be affected.	03/11/2016

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	an emergency. Findings include: Based on review of "Disaster Preparedness Plan" documentation with the Maintenance Supervisor during record review from 9:15 a.m. to 12:15 p.m. on 02/10/16, the written health care occupancy fire safety plan for the facility did not identify the location of smoke barrier doors and fire doors in the facility for the evacuation of smoke compartments. The written fire safety plan states "Residents, staff and visitors in the wing where the disaster is located must be immediately move beyond the nearest smoke/fire barrier doors" and "A second option, the decision must be made as to the feasibility of evacuating the residents horizontally into another area on the nursing unit behind fire doors or into another fire zone free area free from smoke and fire. (SEE DIAGRAM FOR EVACUATION PROCEDURES IN SECTION A)." In addition, the "General Action Fire Plan" section of the written fire safety plan states during an evacuation to "Continue moving in sequence all persons in the area until all are past the fire doors. Do not go back through fire doors unless necessary." The diagram for evacuation procedures for Section A did not identify the location of		**What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** The Disaster Preparedness Plan and the diagrams for theevacuation procedures for the facility identifying the locations of the smokeand fire barrier for the facility will be reviewed annually by the MaintenanceDirector. **How the correctiveactions will be monitored to ensure the deficient practice will not recur, i.e.what quality assurance program will be put into place:** Maintenance Director/Designee will submit the results andany changes to the Quality Assurance Committee for review.	

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	smoke and fire barrier doors. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the location of smoke barrier doors and fire doors are not identified in the written fire safety plan for the facility for evacuation purposes. 3.1-19(b)			
K 0050 SS=F Bldg. 01	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 1. Based on record review and interview, the facility failed to document fire drills conducted on the: a. first shift for 1 of 4 quarters. b. second shift for 1 of 4 quarters. c. third shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Supervisor during record	K 0050	**K-050 (F) What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?** 1.Maintenance Director will conduct scheduled monthly Fire drill and submit report to Administrator for review 2.The Maintenance Director/Designee will utilizethe fire drill form which will ensure all needed information is completed foreach drill conducted including staff that participated in the process.	03/11/2016

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	review from 9:15 a.m. to 12:15 p.m. on 02/10/16, documentation of a fire drill conducted on the first shift in the first quarter (January, February, March) 2015, the second shift in the second quarter (April, May, June) 2015 and the third shift in the fourth quarter (October, November, December) 2015 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged documentation of a fire drill conducted on the aforementioned shifts and quarters in 2015 was not available for review. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to document complete information of fire drills conducted on the first shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Supervisor during record review from 9:15 a.m. to 12:15 p.m. on 02/10/16, documentation for the first shift fire drill conducted in the second quarter (April, May, June) 2015 on		**How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken:** All residents have a potential to be affected by thedeficient practice. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** The Maintenance /Designee will follow the fire drillprotocol and policy as per Life safety guidelines and submit the records ofdrill conducted to the Administrator for review of compliance. **How the correctiveactions will be monitored to ensure the deficient practice will not recur, i.e.what quality assurance program will be put into place:** The Maintenance/Designee will submit the records of firedrills to the Quality Assurance Committee for review.	

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	05/07/15 at 10:23 a.m. did not include staff who participated in the fire drill. Based on interview at the time of record review, the Maintenance Supervisor acknowledged documentation for the first shift fire drill conducted on 05/07/15 at 10:23 a.m. did not include staff who participated in the fire drill. 3.1-19(b) 3.1-51(c)			
K 0056 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on record review, observation and interview; the facility failed to provide sprinkler coverage for 2 of 2 combustible exterior canopies wider than 4 feet. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width.	K 0056	**What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?** Appropriate documentation was not available at time ofsurvey, but documentation has been acquired for the exterior canopies fabricwhich is noncombustible and meets the flame spread rating.	03/11/2016

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	This deficient practice could affect 35 residents, staff and visitors if needing to exit the facility by Room 116 and by Room 136. Findings include: Based on record review with the Maintenance Supervisor from 9:15 a.m. to 12:15 p.m. on 02/10/16, flame spread rating documentation for exterior canopies was not available for review. Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 02/10/16, the exterior canopy at the exit by Room 116 and the exterior canopy be Room 136 each extended six feet from the building, was of fabric construction and was not provided with automatic sprinklers. Based on interview at the time of observation, the Maintenance Supervisor stated documentation was not available for review demonstrating the fabric canopies were noncombustible and acknowledged the aforementioned canopies extended more than four feet from the building, was of combustible construction and was not provided with automatic sprinklers. 3.1-19(b) 3.1-19(ff)		**How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken:** All residents have the potential to be affected **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** The Maintenance Director/Designee will ensure any newinstallation or changes to the canopies meet the criteria for the non-combustiblefabric with flame spread rating. Maintenance Director will also maintainappropriate documentation on file. **How the correctiveactions will be monitored to ensure the deficient practice will not recur, i.e.what quality assurance program will be put into place:** The Maintenance Director/Designee will submit the supportingdocuments for changes to the canopies non-combustible fabric with flame spreadrating to the Quality Assurance Committee for review.	

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K 0062 SS=E Bldg. 01	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 Based on observation and interview, the facility failed to ensure 11 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 50 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 02/10/16, the escutcheon plate was missing for the automatic sprinkler located in the closets for Rooms 208, 209, 301, 303, 305, 307, 321, 331, 333 and the B Wing Nurse's Station Med Room. In addition, the escutcheon plate was missing for the sidewall mounted sprinkler by the B Wing Nurse's Station. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the escutcheon plate were missing for the aforementioned automatic	K 0062	**What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?** Integrated Electronics has been contracted to replace theescutcheon plates for the automatic sprinkler located in the closets for rooms208, 209, 301, 303, 305, 307, 321, 331, 333, B Wing Nurse's station Med Roomand the sidewall mounted sprinkler by the B Wing Nurse's Station. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken:** All residents have the potential to be affected. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** The Maintenance Director/Designee will conduct facility wideinspection of sprinklers located in resident rooms for missing escutcheonplates and provide the lists to the vendor IEI for installation of the plates. TheMaintenance Director/Designee will do quarterly inspection of	03/11/2016

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	sprinkler locations. 3.1-19(b)		sprinklers formissing escutcheon plates. **How the correctiveactions will be monitored to ensure the deficient practice will not recur, i.e.what quality assurance program will be put into place:** The Maintenance Director/Designee will submit the reportafter completing the facility wide inspection of sprinklers and the IEI Report tothe Quality Assurance Committee for review.	
K 0069 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 1. Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1999 edition, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect five staff and visitors in the kitchen. Findings include: Based on review of 360 Services "Report #: FP" documentation dated 01/19/16 with the Maintenance Supervisor during	K 0069	**What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?** 1. Hood Extinguishing System inspection was completed on 2/14/16by outside vendor and documentation is available supporting the completion ofinspection. 2. The Kitchen Exhaust System inspection was completed on 2/14/16by outside vendor. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken:** All Dietary staff have the potential to be affected. **What measures will beput into place or what systemic changes will**	02/14/2016

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	record review from 9:15 a.m. to 12:15 p.m. on 02/10/16, documentation of semiannual hood extinguishing systems inspection six months prior to 01/19/16 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged documentation of semiannual hood extinguishing systems inspection six months prior to 01/19/16 was not available for review. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA		**be made to ensure that thedeficient practice does not recur:** The Maintenance Director/Designee will maintain a log andschedule for the semiannual inspection of the Hood Extinguishing System and theKitchen Exhaust System and submit them to Administrator. **How the correctiveactions will be monitored to ensure the deficient practice will not recur, i.e.what quality assurance program will be put into place:** The Maintenance Director/Designee will provide theinspection reports to the Quality Assurance Committee for review whenever thesemi-annual inspection is conducted.	

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	155620	A. BUILDING 01 B. WING	02/10/2016

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	8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect five staff and visitors in the kitchen. Findings include: Based on review of Richard's Hood & Duct Cleaning Service's "Exhaust Removal System's Report" documentation dated 07/27/15 with the Maintenance Supervisor during record review from 9:15 a.m. to 12:15 p.m. on 02/10/16, documentation of semiannual kitchen exhaust systems inspection six months after 07/27/15 was not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 02/10/16, a sticker was affixed to the kitchen range hood indicating the most recent hood inspection was performed by Richard's Hood & Duct in July 2015. No other kitchen exhaust systems inspection documentation after 07/27/15 was available for review. Based on interview at the time of record review and of the			

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	observation, the Maintenance Supervisor acknowledged documentation of semiannual kitchen exhaust systems inspection six months after July 2015 was not available for review. 3.1-19(b)			
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 1. Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes observed was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect 30 residents, staff and visitors in the vicinity of the B Wing nurses station. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 02/10/16, a 4 inch by 4 inch electrical	K 0147	**What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?** 1.A cover has been placed over the 4 inch by 4inch electrical junction box with two wires connections jutting out of the boxwithout a cover 2.All power strips and extension cords have beenremoved and the wiring fixed in the breakroom for the microwave. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken:** All residents and staff have the potential to be affected. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** The Maintenance Director/Designee	03/11/2016

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	junction box with two wire connections jutting out of the box without a cover was noted on the wall separating the lounge from the B Wing Nurses Station. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned electrical junction box location was without a cover. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 5 staff and visitors in the breakroom by the service hall. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 02/10/16, a microwave oven was plugged into a power strip in the breakroom by the service hall. Based on interview at the time of observation, the Maintenance Supervisor acknowledged a		will conduct facility wideinspection of all electrical junction boxes for missing cover and immediatelyplace covers to the boxes. All staff will be in serviced on utilization ofpower strips and extension cords **How the correctiveactions will be monitored to ensure the deficient practice will not recur, i.e.what quality assurance program will be put into place:** The Maintenance Director/Designee will provide theinspection report to the QA committee for review.	

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	power strip was being used as a substitute for fixed wiring at the aforementioned location. 3.1-19(b)			