STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 01 B. WING	08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE	1900 ANDREW AVE LA PORTE, IN 46350

(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: 08/22/16 Facility Number: 000061 Provider Number: 155136 AIM Number: 100288620 At this Life Safety Code survey, Golden Living Center-Fountainview Terrace 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 was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in spaces open to the corridors with battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 176 and had	K 0000	This Plan of Correction shallserve as this facility's credibleallegation of compliance.Preparation, submission, andimplementation of the Plan ofCorrection does not constitute anadmission of or agreement withthe facts and conclusions setforth in this survey report. OurPlan of Correction is preparedand executed as a means tocontinuously improve the qualityof care and to comply with allapplicable state and federalregulatory requirements. Pleaseconsider allowing the submissionof living center audits andeducation as evidence ofcompliance with the state andfederal requirements identified inthe survey. Respectfully, JerrellHarville, HFA, MSW, ExecutiveDirector.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	a census of 126 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the maintenance garage and storage shed.			
K 0017 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck 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 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, 19.3.6.4, 19.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 1 Garden Dining room and 1 of 1 Main Dining room was separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception. LSC 19.3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas	K 0017	K017- 1. Identified areas, main dining room and gardens dining area, to be outfitted with electrically supervised automatic smoke detectors. 2. Maintenance Director or his designee inspected all other areas to ensure smoke detection devices are in place. 3. Maintenance Director or his designee will make rounds weekly x 4 weeks and then monthly times 6 months to ensure	09/21/2016

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	may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by an automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect staff and up to 45 residents Findings include: Based on observation with the Maintenance Director on 08/22/16 at 12:16 p.m. then again at 12:49 p.m., the Garden Dining room did not have a door and was open to the corridor. Then again, the Main Dining room was open to the corridor. Furthermore, Exception # 6, requirement (a) of the LSC Section 19.3.6.1 was not met because both rooms were not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition. 3.1-19(b)		compliance. 4. Results of Maintenance Directors report will be reviewed at monthly quality review meeting x 6 months. 5. Deficient practice will be remedied by 9/21/16.	
K 0018 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other			

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	than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3			
	1. Based on observation and interview, the facility failed to ensure 1 of 1 Memory Nutrition Pantry, 1 of 1 Kitchen corridor doors would resist the passage of smoke. NFPA 101 Life Safety Code, Section 19.3.6.3.1 requires doors protecting corridor openings shall be constructed to resist the passage of smoke. This deficient practice could affect staff and up to 36 residents. Findings include: Based on observation with the Maintenance Director on 08/22/16 at 11:43 a.m. then again at 12:45 p.m., the Memory Nutrition Pantry corridor door	K 0018	K018 1. Identified areas, Memory nutrition pantry door/kitchen corridor door/corridor door to service hallway, penetrations were repaired and latches in place to maintain compliance. 2. Maintenance director or his designee inspected all other doors for penetrations and effective latching devices. 3. Maintenance Director or his designee will make rounds weekly x 4 weeks and then monthly times 6 months to ensure compliance. 4. Results of Maintenance Directors report will be reviewed at monthly quality review meeting x 6 months. 5. Deficient practice will be remedied by 9/21/16.	09/21/2016

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	contained two separate one quarter inch penetrations. Then again, the Kitchen corridor door contained a quarter inch penetration. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 Service corridor door closed and latched into the door frame. NFPA 101, Life Safety Code, 19.3.6.3.2 requires corridor doors shall be provided with means suitable for keeping the door close. This deficient practice could affect staff and up to 22 residents. Findings include: Based on observation and interview on 08/22/16 at 12:32 p.m., the Maintenance Director acknowledged the corridor door to the Service corridor did not have positive latching hardware latching into the door frame. 3.1-19(b)			
K 0021 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing			

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	and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (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 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. Based on observation and interview; the facility failed to ensure 1 of 1 rolling fire door did not have an impediment to closing. This deficient practice could affect staff and up to 41 residents. Findings include: Based on observation with the Maintenance Director on 08/22/16 at 12:16 p.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room. There was a plastic tub full of silverware directly underneath the rolling fire door. Based on interview at the time of observation, the	K 0021	K021 1. Identified impediment to rolling fire door was removed. 2. All residents were identified as being possibly affected by impediment. Impediment was removed. 3. Maintenance Director or his designee will make rounds weekly x 4 weeks and then monthly times 6 months to ensure compliance. Staff education provided regarding no impediment to rolling fire door should be present 4. Results of Maintenance Directors report will be reviewed at monthly quality review meeting x 6 months. 5. Deficient practice will be remedied by 9/21/16.	09/21/2016

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	Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)			
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 1 of 6 smoke barrier 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 up to 72 residents. Findings include: Based on observation with the Maintenance Director on 08/22/16 from 11:24 a.m. to 2:28 p.m., the following smoke barrier wall penetration and unsealed ceiling penetrations were noted: a) a quarter inch ceiling penetration around cables in the Memory Janitor's closet b) a half inch ceiling penetration around	K 0025	K025 1. Identified areas; memory janitors closet, villa janitor closet, central supply room, sprinkler pipe near room 23, were all repaired with fire caulk to ensure compliance. 2. All residents were identified as being potentially affected by deficient practice. Maintenance director or his designee will make rounds weekly to ensure any penetrations to smoke barriers are sealed appropriately and in compliance. 3. Maintenance Director or his designee will make rounds weekly x 4 weeks and then monthly times 6 months to ensure compliance. Staff education provided regarding no impediment to rolling fire door should be present 4. Results of Maintenance Directors report will be reviewed at monthly quality review meeting x 6 months.	09/21/2016

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	cables in the Villa Janitor's closet c) one half of one out of twelve ceiling tiles were missing in the Central Supply room d) a half inch gap around sprinkler pipe in the smoke barrier near resident room 23. Based on interview at the time of each observation, the Maintenance Director acknowledged and provided the measurements for each unsealed penetration. 3.1-19(b)		5. Deficient practice will be remedied by 9/21/16.	
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Garden Soiled Linen room and 1 of 1 Dish room, both hazardous areas containing more than 64 gallons of soiled linen and or trash, was provided with a self-closer and/or would positively latch into the frame. This deficient	K 0029	K029 1. The identified area, the door to the dish room and Gardens soiled linen room door was repaired. Popcorn Popper labeled only to used in kitchen area, behind self closing fire doors. 2. All residents are potentially affected by the deficient practice. All self closing devices were inspected by	09/21/2016

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	practice could affect staff and up to 45 residents. Findings include: Based on observation with the Maintenance Director on 07/19/16 at 12:14 p.m. then again at 12:37 p.m., the corridor door to the Garden Soiled Linen room did not have a self-closing device installed. Then again, the corridor door to the Dish room failed to positively latch into the frame when tested. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 hazardous cooking areas was protected by a self-closing door. This deficient practice could affect up to 41 residents. Findings include: Based on observation with the Maintenance Director on 08/22/16 at 12:55 p.m., a mobile popcorn popper was in the Activity room. The two Activity room corridor doors did not have self-closing devices installed. Based on interview at the time of observation, the		maintenance director or his designee to ensure compliance. Activity staff educated to only used popcorn popper in designated area behind self closing fire doors. 3. Maintenance Director or his designee will make rounds weekly x 4 weeks and then monthly times 6 months to ensure compliance. 4. Results of Maintenance Directors report will be reviewed at monthly quality review meeting x 6 months. 5. Deficient practice will be remedied by 9/21/16.	

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	Maintenance Director acknowledged that vegetable oil is used to cook the popcorn and was being operated in the Activity room. 3.1-19(b)			
K 0038 SS=E Bldg. 01	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 Based on observation, record review, and interview, the facility failed to ensure 2 of 13 exits had a correct code posted. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect staff and up to 46 residents. Findings include: a) Based on observation with the	K 0038	K038 1. Doors/exits identified: exit door by room 205 and Ambulance entrance door had codes posted to allow exit. 2. All exit doors had exit code posted to allow egress and to ensure compliance with regulations. 3. All exit doors will be reviewed by maintenance director or his designee monthly x 6 months and quarterly thereafter to ensure codes are posted. 4. Results of Maintenance Director's reports will be reviewed at monthly quality review meeting x 6 months. 5. Deficient practice will be remedied by 9/21/16	09/21/2016

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	Maintenance Director on 08/22/16 at 11:20 a.m., the exit door by resident room 205 was held in the locked position with a magnetic hold down device. Furthermore, the exit door was equipped with an electronic keypad entry system that allowed staff to open the locked exit doors with a combination. A code posted failed to open the door. Based on an interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed that the code has changed and the sign needed to be updated b) Based on observation with the Maintenance Director on 08/22/16 at 11:51 a.m., the "Ambulance Staff Entrance" exit door was held in the locked position with a magnetic hold down device. Furthermore, the exit door was equipped with an electronic keypad entry system that allowed staff to open the locked exit doors with a combination. A code was not posted. Based on an interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)			
K 0046 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in			

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	accordance with 7.9. 18.2.9.1, 19.2.9.1. Based on record review and interview; the facility failed to ensure 2 of 2 battery operated emergency lights in the facility was maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test o be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour 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 staff only. Findings include: Based on observation with the Maintenance Director on 08/22/16 at 11:57 a.m., two battery operated emergency lights were discovered in the Boiler room. Based on interview at the time of observation, the Maintenance Director was unable to provide any testing documentation. 3.1-19(b)	K 0046	K046 1. Identified battery operated emergency lights in boiler room were tested for compliance. 2. No residents were identified as being affected by this practice. 3. Maintenance Director or Designee will test and log results of battery operated emergency lights monthly x 6 months and quarterly thereafter to ensure compliance. 4. Maintenance Director reports will be reviewed at monthly quality review meeting x 6 months to ensure compliance 5. Deficient practice will be remedied by 9/21/16	09/21/2016

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K 0048 SS=E 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 provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect staff and up to 11 residents. Findings include: Based on a record review with the Maintenance Director on 08/22/16 between 10:50 a.m. and 2:32 p.m., the facility had a written fire policy that horizontal evacuation would be performed by crossing a smoke barrier. However, there were corridor doors that were not complete smoke or fire barriers	K 0048	K048 1. Fire Safety Plan is present and available at each nurses station in the Emergency Binder tab 14. Non smoke barrier doors were labeled as non smoke barriers. 2. Fire Safety Plan is present and available at each nurses station in the Emergency Binder tab 14. Non smoke barrier doors were labeled as non smoke barriers. Staff education provided to ensure knowledge of fire safety plan. 3. Maintenance Director or Designee will review Fire Safety Plan in Emergency Binders at nurses stations monthly x 6 months and quarterly thereafter to ensure compliance. 4. Maintenance Director reports will be reviewed at monthly quality review meeting x 6 months to ensure compliance 5. Deficient Practice will remedied by 9/21/16.	09/21/2016

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	which could cause staff to evacuate residents to a different part of the same smoke compartment and not to an adjacent compartment in the event of a fire. Based on observation, there was a set of doors not part of a complete barrier in the Villa hall. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed the set of doors were used for security purposes. 3.1-19(b)			
K 0050 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 Based on record review and interview, the facility failed to ensure 9 of 12 fire drills were conducted under varied conditions. This deficient practice affects all occupants in the facility including staff, visitors and residents.	K 0050	K050 1. Fire Drills will be held on varying shifts, and varying times each month to ensure compliance. 2. All residents are potentially affected therefore: Fire Drills will be held on varying shifts, and varying	09/21/2016

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	155136	A. BUILDING 01 B. WING	08/22/2016

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	Findings include: Based on record review with the Maintenance Director on 08/22/16 at 9:55 a.m., 9 of 12 fire drills conducted over the past four quarters were conducted on or after the 28th of each month. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b) 3.1-51(c)		times each month to ensure compliance. 3. Maintenance Director or his Designee will record fire drills monthly to ensure compliance.. 4. Maintenance Director's reports will be reviewed at monthly quality review meeting x 6 months to ensure compliance 5. Deficient practice will be remedied by 9/21/16	
K 0053 SS=F Bldg. 01	NFPA 101, 483.70(a)(7) LIFE SAFETY CODE STANDARD In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. 42 CFR 483.70(a)(7) Based on record review and interview, the facility failed to maintain 72 of 72 single station smoke detectors per manufacturer's recommendation. 410 IAC 16.2 Licensure of Health Facilities Rules at 16.2-3.1-19(ff)(3) requires a health facility licensed under IC 16-28 and this rule to have a battery operated or hard-wired smoke detector in each	K 0053	K053 1. Batteries were changed in identified battery operated smoke detectors. Battery operated smoke detectors are to be tested monthly to ensure compliance. Results of tests will be logged by maintenance director. 2. All residents are potentially affected by this practice. Battery operated smoke detectors were tested to ensure compliance. All battery operated	09/21/2016

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	resident room before July 1, 2012. This deficient practice affects all residents. Findings include: Based on record review with the Maintenance Director on 09/22/16 at 10:10 a.m., the "Battery-operated Smoke Detector Log for 2016" indicated the single station smoke detectors batteries were last replaced on 06/01/16. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition and confirmed no other documentation is available for review. 3.1-19(b)		smoke detectors are to be tested monthly to ensure compliance. Results of tests will be logged by maintenance director. 3. Maintenance director or his designee will test battery operated smoke detectors monthly and log results. 4. Maintenance Director's reports will be reviewed at monthly quality review meeting x 6 months to ensure compliance 5. Deficient practice will be remedied by 9/21/16	
K 0070 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 Based on observation and interview, the facility failed to ensure 1 of 1 policy prohibiting space heaters was maintained. This deficient practice could affect staff and up to 41 residents. Findings include:	K 0070	K070 1. Identified violation was removed from the facility. 2. All residents are potentially affected by this deficient practice. Staff education provided that space heating devices were prohibited within the facility.	09/21/2016

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	Based on observation with the Maintenance Director on 08/22/16 at 1:00 p.m., a space heater was discovered in the Resources office. Based on interview review, the Maintenance Director acknowledged the aforementioned condition and confirmed the facility has a policy not allowing space heaters at all. 3.1-19(b)		3. Staff education provided as to the fact that space heating devices were prohibited within the facility. Maintenance director or his designee will make rounds weekly x 4 week and monthly x 6 months to ensure no violations are present. 4. Maintenance reports will be reviewed in monthly quality review meeting x 6 months to ensure continued compliance. 5. Deficient practice remedied by 9/21/16	
K 0074 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3			

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	o Newly introduced upholstered furniture and mattresses means purchased since March, 2003. Based on observation and interview, the facility failed to ensure 2 of 2 window curtains in the Laundry room was flame retardant. This deficient practice could affect staff only. Findings include: Based on observations with the Maintenance Director on 08/22/16 12:33 p.m., there were two separate window curtain in the Laundry room. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed there was no documentation was available for review. 3.1-19(b)	K 0074	K074 1. Identified curtains were removed from the facility. 2. No residents were potentially affected by this practice. 3. Maintenance to review all window covering to ensure compliance with regulations. Maintenance director or his designee will make rounds weekly x 4 weeks then monthly times 6 months to ensure continued compliance 4. Maintenance reports will be reviewed in monthly quality review meeting x 6 months to ensure continued compliance. 5. Deficient practice remedied by 9/21/16	09/21/2016
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 2 of 2 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	K 0147	K147 1. Identified cords were removed in order to comply with regulations. 2. All residents could potentially be affected by this practice. Therefore Weekly rounds will be conducted to ensure compliance with regulatory guidelines. 3. Maintenance Director or designee will complete weekly rounds x 4	09/21/2016

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	cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 15 residents. Findings include: Based on observation with Maintenance Director on 08/22/16 at 11:30 a.m. then again at 11:45 a.m., an extension cord was powering a cell phone in resident room 210. Then again, a surge protector was powering a coffee pot in the Memory Unit Coordinator's office. Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition. 3.1-19(b)		weeks and monthly rounds x 6 months to ensure compliance is maintained. 4. Maintenance reports will be reviewed in monthly quality review meeting x 6 months to ensure continued compliance. 5. Deficient practice remedied by 9/4/15.	