STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	08/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(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: 08/14/17 Facility Number: 002982 Provider Number: 155700 AIM Number: 200382090 At this Life Safety Code survey, Catherine Kasper 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 2012 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 two story facility with a basement was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 81 and had a census of 77 at the time of this survey.	K 0000	Submission of the response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Executive Director, or other associates, agents, or other individuals who draft or may be discussed in this response and plan of corrections. Preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any fact a alleged or the corrections of any conclusion set forth in these allegations by the survey agency.	

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

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	All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 08/18/17 - DA			
K 0131 SS=D Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: * They are not intended to serve four or more inpatients. * They are separated from areas of health care occupancies by construction having a minimum 2-hour fire resistance rating in accordance with Chapter 8. * The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623			
	1. Based on observation and interview, the facility failed to maintain protection of 1 of 1 Health Care/ Tunnel fire barrier wall was maintained in accordance of 19.1.3.2. This deficient practice could affect staff only. Findings include:	K 0131	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice. Tunnel door now has astragal and a door coordinator installed. The penetration above the drop ceiling have been filled. 2. How other residents having the	09/13/2017

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	Based on observation with the Maintenance Technician #1 on 08/14/17 at 12:26 p.m., of the Health Care/ Tunnel fire barrier wall double cross corridor doors, the doors did not have an astragal, and no coordinating device installed. Centers for Medicare & Medicaid Services (CMS) requires sets of 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. Based on interview at the time of observation, the Maintenance Technician #1 acknowledged he was unaware of the aforementioned CMS requirements. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 Health Care/ Tunnel fire barrier wall was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical,		potential to be affected by the same deficient practice will be identified and what corrective action will be taken; This deficient practice would affect staff only. Audits of doors and potential penetrations will be monitor. 3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur. Maintenance will be trained on proper door closing according to CMS. 4.How will the corrective action be monitored to ensure that the deficient does not recur Maintenance will audit all doors monthly times 3 months for proper door closing and penetrations. Audits will be presented Quality Assurance Committee for their review until compliance achieved. Date of Compliance 9/13, 2017	

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	mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice could affect staff only. Findings include: Based on an observation with the Maintenance Technician #1 on 08/14/17 at 12:55 p.m., the Health Care/ Tunnel fire barrier occupancy separation contained two separate one half inch penetrations above the drop ceiling. Based on interview at the time of observation, the Maintenance Technician #1 provided the measurements. 3.1-19(b)			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the			

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	means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to maintain 2 of 16 corridors from obstructions per 19.7.10. LSC 7.1.10. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. LSC 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits or their access thereto, egress therefrom, or visibility thereof. This deficient practice could affect staff and up to 14 residents. Findings include: Based on observation with the Executive Director and the Maintenance Technician #1 on 08/14/17 at 11:20 a.m. then again at 11:52 a.m., a Christmas tree was discovered in the corridor outside of Director of Nursing office. Then again, a bookshelf unit was in the corridor outside of first floor restrooms. Based on interview at the time of each observation, the Executive Director and the Maintenance Technician #1 acknowledged that impediments such as the Christmas tree and the bookshelf unit were potential impediments to full use of	K 0211	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice. Tree and bookcase were removed 8/15/2017. All halls were audited for any other potential impediments. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; This deficient practice would affect staff and 14 residents. Audits will be completed by Maintenance or designee for potential impediments. 3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur All staff will be trained on potential impediments in building. 4.How will the corrective action be monitored to ensure that the deficient does not recur Maintenance will audit all areas weekly times 2 for 1 months for potential impediments in building. Audits will be presented Quality Assurance Committee for their review until compliance achieved.	09/13/2017

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	the means of egress access corridors 3.1-19(b)			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on record review and interview; the facility failed to install exit signage in 3 of 12 corridors in the facility in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. This deficient practice could affect staff and at least 38 residents. Findings include: Based on observation with the Executive Director and the Maintenance Technician #1 on 08/14/17 between 10:55 a.m. and 12:45 a.m., the following exit doors contained a sign stating "STOP" with an exit sign above the door:	K 0293	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice. . Stop sign was removed from door 8/14/2017. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; This deficient practice could affect staff and residents. Audits will be completed by Maintenance or designee for improper signage on exit doors. 3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur All staff will be trained on proper signage on exit doors in building 4.How will the corrective action be	09/13/2017

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	a) 2nd floor stairwell door near resident room 257 b) 2nd floor stairwell door near resident room 235 c) 1st floor stairwell door near resident room 138 d) Basement/ Tunnel exit door by the Maintenance office Based on interview at the time of each observation, the Administrator and the Maintenance Director acknowledged the conflicting exit directions. 3.1-19(b)		monitored to ensure that the deficient does not recur Maintenance will audit all areas weekly times 2 for 1 months for proper signage on exit doors in building. Audits will be presented Quality Assurance Committee for their review until compliance achieved.	
K 0311 SS=D Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the facility failed to maintain protection of 1 of 1 Laundry chute vertical shafts was in accordance of 19.3.1. LSC 19.3.1 requires protection of vertical opening 39.3.1. LSC 19.3.1 requires vertical opening shall be enclosed or protected in	K 0311	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice. Penetrations on first floor laundry chute have been filled. 2. How other residents having the potential to be affected by the	09/13/2017

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	accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 19.3.1.1 requires where an enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. This deficient practice could affect staff only. Findings include: Based on observation with the Executive Director and the Maintenance Technician #1 on 08/14/17 at 11:36 a.m., two penetrations were in the 1st floor portion of the Laundry chute vertical opening. One penetration measured two inches by three inches. Another penetration measured two inches by eight inches. Based on interview at the time of observation, the Maintenance Technician #1 acknowledged the penetrations in the Laundry chute and provided the measurements for the penetrations. 3.1-19(b)		same deficient practice will be identified and what corrective action will be taken; This deficient practice could affect staff only. Audits will be completed by Maintenance or designee for penetration areas. 3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur Audits will be completed by Maintenance or designee for penetration areas. 4.How will the corrective action be monitored to ensure that the deficient does not recur Maintenance will audit all areas weekly times 2 for 1 month for penetrations in building. Audits will be presented Quality Assurance Committee for their review until compliance achieved.	
K 0321 SS=D Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved			

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	automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220)			
	Based on observation and interview, the facility failed to maintain protection of 1 of 1 Basement Soiled Linen in accordance of 19.3.2. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Technician #1 on 08/14/17 at 12:20 p.m., the Basement Soiled Linen contained double corridor doors. The	K 0321	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice. Soiled laundry room an astragal was added to door, the door coordinator was already in place. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; This deficient practice could affect staff only. Audits will be	09/13/2017

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	doors did not have an astragal, and no coordinating device installed. Centers for Medicare & Medicaid Services (CMS) requires sets of 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. Based on interview at the time of observation, the Maintenance Technician #1 acknowledged he was unaware of the aforementioned code requirements. 3.1-19(b)		completed by Maintenance or designee for other potential door closure concerns. 3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur Maintenance will be trained on proper door closing according to CMS 4.How will the corrective action be monitored to ensure that the deficient does not recur Maintenance will audit all doors monthly times 3 months for proper door closing . Audits will be presented Quality Assurance Committee for their review until compliance achieved. Date of Compliance 9/13/2017	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm	K 0346	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice. Fire watch policy as been reviewed and updated, now	09/13/2017

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	system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on record review with the Executive Director and the Maintenance Technician #1 on 08/14/17 at 10:05 a.m., the facility provided fire watch documentation but it was incomplete. The plan failed to include contacting the Indiana State Department of Health via the Web Portal. Based on an interview record review, the Executive Director and the Maintenance Technician #1 acknowledged fire watch policy failed to include the web link for contacting the Incident Reporting System located on the Indiana State Department of Health (ISDH) Gateway. 3.1-19(b)		states to contact ISBH through the Incident Reporting System. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; This deficient practice could affect all occupants. Maintenance will be inserviced on proper notification to ISDH will fire alarm system is out of order. 3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur Fire Watch Policy will be reviewed quarterly times 2 quarters and yearly there after. 4.How will the corrective action be monitored to ensure that the deficient does not recur Maintenance will audit Fire Watch Policy quarterly times 2 quarters first review will be 9/13/2017 . Audits will be presented to Quality Assurance Committee for their review until compliance achieved. Date of Compliance 9/13/2017	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are			

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	determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)			
	Based on record review and interview, the facility failed to provide a 1 of 1 written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all occupants. Findings include: Based on record review with the Executive Director and the Maintenance Technician #1 on 08/14/17 at 10:05 a.m., the facility provided fire watch	K 0354	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice. Fire watch policy now states to contact ISBH through the Incident Reporting System 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; This deficient practice could affect all occupants. Maintenance will be inserviced on proper notification to ISDH when sprinkler system is out of order. 3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur Fire Watch Policy will be reviewed quarterly times 2 quarters and yearly there after. 4.How will the corrective action be monitored to ensure that the deficient does not recur	09/13/2017

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	documentation but it was incomplete. The plan failed to include contacting the Indiana State Department of Health via the Web Portal. Based on an interview record review, the Executive Director and the Maintenance Technician #1 acknowledged fire watch policy failed to include the web link for contacting the Incident Reporting System located on the Indiana State Department of Health (ISDH) Gateway. 3.1-19(b)		Maintenance will audit Fire Watch Policy quarterly times 2 quarters first review will be 9/13/2017 . Audits will be presented to Quality Assurance Committee for their review until compliance achieved. Date of Compliance 9/13/2017	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 4 of 16 smoke barrier walls were protected to maintain the	K 0372	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice. All of the mentioned penetrations have been filled and audit	09/13/2017

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

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	smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff and at least 29 residents. Findings include: Based on observations with the Maintenance Technician #1 on 08/14/17 between 1:03 p.m. and 1:36 p.m., the following unsealed penetrations were discovered: a) one inch penetration through conduit in the 1st floor B wing smoke barrier above the drop ceiling b) one inch penetration through conduit in the 1st floor A wing smoke barrier above the drop ceiling c) a three inch penetration in the resident room 178 smoke barrier above the drop ceiling. Additionally, the drywall did not fully extend to the under side of the ceiling d) three separate two inch penetrations in the resident room 290 smoke barrier above the drop ceiling Based on interview at the time of each observation, the Maintenance Technician #1 confirmed all cross corridor doors were smoke barriers and provided the measurements.		completed for any other penetrations. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; The penetrations could affect both resident and staff. Maintenance audit completed for any other penetrations. 3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur Maintenance will audit building for other potential penetrations. 4.How will the corrective action be monitored to ensure that the deficient does not recur Maintenance will audit facility for penetrations 2 times per week times one monthly for penetrations. Audits will be presented to Quality Assurance Committee for their review until compliance achieved. Date of Compliance 9/13/2017	

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	3.1-19(b)			
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 electrical junction boxes observed were maintained in a safe operating condition in accordance with 19.5.1.1. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, 2011 Edition, Article 314.28(C) requires all pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Technician #1 on 08/14/17 at 1:03 p.m. then again at 1:33 p.m., there	K 0511	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice. The first floor B-wing was covered properly. It was in first floor dining room where electrical box was not covered properly. Electrical boxes are now covered, audit completed of all electrical boxes. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; This will affect staff only.Audits will be completed by maintenance for concerns with electrical boxes. 3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur Maintenance or designee will do complete audit of electrical boxes	09/13/2017

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	was exposed wiring in an electrical box without a cover in the 1st floor B smoke barrier above the drop ceiling. Then again, there was exposed wiring in an electrical box without a cover in room 244 smoke barrier above the drop ceiling. Based on interview at the time of observation, the Maintenance Technician #1 acknowledged the aforementioned condition. 3.1-19(b)		for covers. 4.How will the corrective action be monitored to ensure that the deficient does not recur Maintenance will audit facility for covers on electrical boxes 2 times per week times one month for non covered electrical boxes. Audits will be presented to Quality Assurance Committee for their review until compliance achieved. Date of Compliance 9/13/2017	
K 0521 SS=D Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on observation and interview; the facility failed to ensure at least 3 of 3 fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in	K 0521	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice. Catherine Kasper will have contractor inspect damper system by Sept 5th 2017. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; This will affect staff only. After inspection facility will take corrective action if needed.	09/13/2017

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	accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect staff only. Findings include: Based on record review with the Executive Director and the Maintenance Technician #1 on 08/14/17 at 11:15 a.m. then again at 12:30 p.m., dampers were discovered on HVAC tubing in the Mechanical room by resident room 222. Then again, dampers were discovered on HVAC tubing in the Basement elevator room. Based on interview at the time of		3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur Contractor to review system on 9/5/17 4.How will the corrective action be monitored to ensure that the deficient does not recur Maintenance will audit dampers 2 times per week times one month for dampers and air flow. Audits will be presented to Quality Assurance Committee for their review until compliance achieved. Date of Compliance 9/13/2017	

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	each observation, the Executive Director and the Maintenance Technician #1 were unaware of the dampers and confirmed no documentation was available for inspection and testing. 3.1-19(b)			
K 0531 SS=D Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 Based on interview and observation, the facility failed to maintain testing of 2 of 2 elevators provided with firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency	K 0531	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice. Schindler Elevators will provide training to Maintenance on recall procedure and documentation 9/12/2017	09/13/2017

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	operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice would affect staff only. Findings include: Based on observation with the Executive Director and the Maintenance Technician #1 on 08/14/17 at 10:45 a.m., there were two elevators located in the health care portion of the building equipped with elevator firefighter recall. Based on interview at the time of observation, the Executive Director and the Maintenance Technician #1 acknowledged the elevators were equipped with elevator firefighter recall; no monthly inspection documentation was available for review and were unaware of the monthly inspection requirement. 3.1-19(b)		2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; Staff would only be affected 3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur Maintenance will maintain monthly log and findings per elevator 4.How will the corrective action be monitored to ensure that the deficient does not recur Maintenance will audit elevators monthly for recall. Audits will be presented to Quality Assurance Committee for their review until compliance achieved. Date of Compliance 9/13/2017	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: * Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product.			

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	* Decorations meet NFPA 701. * Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. * Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6 or 19.7.5.6. * The decorations in existing occupancies are in such limited quantities that a hazard of fire is not present. 18.7.5.6, 19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 1 resident room 286, 1 of 1 resident room 275, 1 of 1 "Lobby Hole", 1 of 1 Library was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect staff and up to 36 residents. Findings include: Based on observation with the Executive Director and the Maintenance Technician #1 on 08/14/17 between 11:25 a.m. and 12:02 p.m., the following was discovered: a) a candle with a wick in resident room 286 b) five candles with wicks in resident room 275 c) a candle with a wick in a display cabinet in the "Lobby Hole" d) a candle with a wick in the Library Based on interview at the time of each	K 0753	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice. All candles have been removed from rooms. With the exception of the Chapel where a candle log will be kept for lighting and extinguishing. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; This practice could affect staff and residents. Per new policy candles will only be allowed in Chapel, where there is a log for proper documentation. 3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur Audits will be completed in the facility to check for candles 4.How will the corrective action be monitored to ensure that the deficient does not recur	09/13/2017

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	observation, the Executive Director and the Maintenance Technician #1 confirmed each candle contained a wick and removed the candles at the time of each observation. 3.1-19(b)		Maintenance will audit facility 2 times per week for candles times one month. Audits will be presented to Quality Assurance Committee for their review until compliance achieved.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation, record review, and interview, the facility failed to install 1 of 1 power strip according to 9.1.2.	K 0920	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice.	09/13/2017

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	LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 110.3(B) Installation and Use, states listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. This deficient practice affects staff and up to 12 residents. Findings include: Based on observation with the Executive Director and the Maintenance Technician #1 on 08/14/17 at 11:06 a.m., a medical grade power strip was powering an IV, the bed, and a television in resident room 240. Based on interview at the time of observation, the Executive Director and the Maintenance Technician #1 acknowledged the medical grade power strip was powering medical equipment and non patient-care-related electrical equipment. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with		Medical equipment removed from power strip and plugged into emergency outlet 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; This has the potential to affect staff and residents 3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur We will create or revise policy and inservice all staff on correct procedure of power strips. Maintenance to audit. 4.How will the corrective action be monitored to ensure that the deficient does not recur Maintenance will audit facility 2 times per week for proper use of power stripes times one month. Audits will be presented to Quality Assurance Committee for their review until compliance achieved. Date of Compliance 9/13/2017	

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	NFPA 70, National Electrical Code. NFPA 70, 2011 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 at least 5 residents. Findings include: Based on observation with the Executive Director and the Maintenance Technician #1 on 08/14/17 at 11:55 a.m., a surge protector was powering an iron in the Activities room. Based on interview at the time of observation, the Executive Director and the Maintenance Technician #1 acknowledged a high-amperage device in a surge protector. 3.1-19(b)			
K 0927 SS=D Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to			

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	portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfill room was protected in accordance with 9.3.7.5.3.1. 2012 NFPA 99 9.3.7.5.3.1 requires oxygen transfill mechanical exhaust rooms to maintain a negative pressure continuously. This deficient practice could affect staff only. Findings include: Based on observation with the Executive Director and the Maintenance Technician #1 on 12/13/16 at 9:40 a.m., the oxygen transfill room fan was running and was confirmed by checking with a piece of paper. A switch near the air vent was flipped and the piece of paper dropped. Based on interview at the time of observation, the Executive Director confirmed the switch turns off the fan and stated the staff would not turn the fan off. 3.1-19(b)	K 0927	1.What corrective action will be accomplished for those residents found to have been affected by deficient practice. The fan switch has been removed so fan will stay on at all times. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; This will affect staff only 3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur Maintenance will complete audits and all staff will be inserviced. 4.How will the corrective action be monitored to ensure that the deficient does not recur Maintenance will audit facility 2 times per week for one month for fan switch being on in oxygen exchange room . Audits will be presented to Quality Assurance Committee for their review until compliance achieved. Date of Compliance 9/13/2017	09/13/2017