STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155621	A. BUILDING 01 B. WING	08/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HAVEN HEALTH AND REHABILITATION CENTER	3400 STOCKER DR EVANSVILLE, IN 47720

(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: 08/15/16 Facility Number: 000442 Provider Number: 155621 AIM Number: 100266510 At this Life Safety Code survey, Pine Haven Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. The original two story section and Stocker Addition I were surveyed with Chapter 19, Existing Health Care Occupancies. This building consists of two sections; the original portion of the building was a two story, fully sprinklered building determined to be of Type I (332) construction, and the Stocker Addition I was a one story, fully sprinklered	K 0000	By submitting the Plan of Correction, the facility is not admitting to the truth or accuracy of the cited deficiencies or allegations. The facility reserves the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the Plan of Correction be considered our allegation of compliance, effective on or before August 29th, 2016, to the cited deficiencies of the Life Safety Code Recertification and State Licensure Survey with an exit date of August 15th, 2016.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	building determined to be of Type V (111) construction. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms in the Stocker Addition I, plus battery operated smoke detectors in all resident sleeping rooms in the original two story section. The facility has a capacity of 113 and had a census of 65 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except, two detached buildings used for facility storage. Quality Review completed on 08/18/16 - DA			
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 1 of over 20	K 0029	Regarding the combustible material (which consisted of paper products for the dietary	08/16/2016

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	hazardous area room doors, such as a room over 50 square feet containing combustible material, was equipped with a self-closing device on the door. This deficient practice could affect mostly staff while in the Harmony Unit north corridor which includes the kitchen. Findings include: Based on observation on 08/15/16 at 11:46 a.m. during a tour of the facility with the Maintenance Director, the corridor door to room 115 was not provided with a self-closing device. Room 115 was being used as a storage room and was full of cardboard boxes and wheel chairs. This room was over fifty square feet. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 4 bathroom/shower rooms, which contained soiled linen containers with a capacity over 32 gallons, was equipped with a self-closing device on the corridor door. This deficient practice could affect residents, as well as staff while in the 200 hall north shower room.		department) observed in Room #115,all combustible material has been removed from said room and placed in a different storage room with a self-closing device on the door. Regarding the North Unit shower room in which soiled linen barrels and one trash barrel were observed, on 8/16/2016, a self-closing device was installed on that bathroom door to ensure compliance. Following the survey exit conference, the Maintenance Director and Housekeeping Supervisor toured the facility to ensure all other areas of potential concern were in compliance. Additionally, another line item has been added to the weekly Preventative Maintenance (PM) schedule that reminds the Maintenance Director to identify and immediately correct any potential future issues related to the inappropriate storage of combustible materials. Each month the Maintenance Director will submit copies of these PM schedules to the Administrator for her review, as a means of ensuring ongoing compliance. If concerns continue to be noted following this review, additional in-servicing and/or counseling with appropriate staff will take place as necessary.	

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	Findings include: Based on observation on 08/15/16 at 12:30 p.m. during a tour of the facility with the Maintenance Director, the 200 hall north shower room had two soiled linen barrels and one trash barrel each over 32 gallons stored within. The door to the corridor was not provided with a self-closing device. This was acknowledged by the Maintenance Director at the time of observation. 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 fire drills were held at varied times for 1 of 3 employee shifts during 3 of 4 quarters.	K 0050	This deficient practice has not resulted in any negative outcomes for any residents or staff; however, as the finding states,all residents had the	08/16/2016

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	This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drills on 08/15/16 at 10:45 a.m. with the Maintenance Director present, three of four, third shift (night) fire drills were performed between 5:45 a.m. and 6:30 a.m. During an interview at the time of record review, the Maintenance Director acknowledged the times the third shift fire drills were performed and agreed the times were not varied enough. 3-1.19(b)		potential to be affected by this deficient practice. In order to ensure that the times for the facility's fire drills vary enough to keep staff, residents, and visitors alert and prepared in the event of a fire, the Fire Drill Tracking Tool has been updated to include pre-determined dates and times for all future drills. This update will ensure varied times and days are being tested for each and every shift, including both weekend days. (Please see attached Fire Drill Tracking Tool.) The Fire Drill Tracking Tool will be routinely completed by the Maintenance Director and be reviewed monthly with the Administrator to ensure ongoing compliance. Any issues noted during this review will be promptly addressed.	
K 0051 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible			

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	and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 Based on observation and interview, the facility failed to ensure 1 of 17 manual fire alarm boxes was readily accessible. NFPA 72, The National Fire Alarm Code, 2-8.2.1 states manual fire alarm boxes shall be distributed throughout the protected area so that they are unobstructed, readily accessible, and located in the path of exit from the area. This deficient practice affect all residents, as well as staff and visitors in the facility. Findings include: Based on observation on 08/15/16 at 12:50 p.m. during a tour of the facility with the Maintenance Director, the manual fire alarm pull station at the smoke barrier doors between Stocker I and Stocker II cross corridor between rooms 311 and 400 was located on the wall behind the east side smoke barrier door while held open with the magnetic door holder. This was acknowledged by the Maintenance Director at the time of observation.	K 0051	This apparently deficient practice has not resulted in negative outcomes for any residents or staff; however, as the finding states, all residents (especially those on the Stocker I and II units)had the potential to be affected by this presumably deficient practice. As part of the effort to attain compliance, the facility's Maintenance Director and Administrator met with representatives from the facility's fire and safety contractor (i.e., Priority One Fire and Security) to discuss the placement of the manual fire alarm pull station located on the wall behind the smoke barrier doors near Room #311. Upon further research, it was determined that the fire alarm box referenced in the survey finding had been placed near what was, originally, an exit door (i.e., prior to the construction of the Stocker II addition in 2005). However, as part of the construction of the Stocker II unit, this exit door was converted to its current function as a set of smoke barrier doors; therefore, a determination has been made that this manual fire alarm pull station can be safely eliminated	08/29/2016

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	3.1-19(b)		entirely. Priority One Fire and Security has confirmed that sufficient fire alarm boxes have been installed at the appropriate places in the facility to ensure both safety and compliance with applicable regulatory requirements. Priority One will continue to do quarterly assessments of the facility's fire alarm stations and smoke detection systems to ensure all equipment and systems are operational and reliable. The Maintenance Director will retain copies of the reports resulting from all such contractor assessments.	
K 0062 SS=F 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 record review, observation and interview; the facility failed to ensure 1 of 1 private fire hydrants was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected and the necessary corrective	K 0062	This deficient practice has not resulted in negative outcomes for any residents or staff; however, as the finding states, all residents had the potential to be affected by this deficient practice.Immediately following the survey exit conference, the Maintenance Director	08/31/2016

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	action shall be taken. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of preventive maintenance records in the Fire and Sprinkler book on 08/15/16 at 11:10 a.m. with the Maintenance Director present, there was no documentation to show the facility's one fire hydrant has had an annual inspection since 05/11/15. Based on interview at the time of record review, the Maintenance Director said the facility's one fire hydrant has not been inspected during the past twelve months. Based on observation between 11:45 p.m. and 2:00 p.m. during a tour of the facility with the Maintenance Director, there was one private fire hydrant on the facility's property. 3.1-19(b)		contacted the facility's local contractor to schedule a prompt inspection of the private fire hydrant. This contractor (i.e., Southwest Sprinkler) is now scheduled to inspect the fire hydrant (with the assistance of the Evansville Water and Sewer Utility) prior to the end of August, 2016.Additionally, the facility has added another line item to the monthly Preventative Maintenance (PM) schedule to remind the Maintenance Director to monitor the fire hydrant inspection record each month. When monitoring indicates that the facility is within three (3) months of the next inspection "due date", a call will be placed to Southwest Sprinkler to schedule the required inspection visit.Prior to the facility's	

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			regularly scheduled quarterly Quality Assurance meetings, the Maintenance Director will submit to the Administrator copies of all PM schedules to ensure ongoing compliance with the requirement to annually inspect the fire hydrant in question.	
K 0072 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD 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. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 10 corridor means of egress was continuously maintained free of obstructions. This deficient practice could affect up to 12 residents, as well as staff and visitors in the Stocker I and Stocker II 300 and 400 west corridor. Findings include: Based on an observation on 08/15/16 at	K 0072	This deficient practice has not resulted in negative outcomes for any residents or staff; however, as the finding states,any residents, staff, or visitors located on the west corridor of the Stocker I or II units during an emergency had the potential to be	08/16/2016

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	12:52 p.m. and again at 1:45 p.m. during a tour of the facility with the Maintenance Director, the Stocker I and Stocker II 300 and 400 hall west corridor had three wheeled carts and three chairs stored in the corridor. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)		affected by this deficient practice.Within hours of this concern being brought to the attention of the Maintenance Director, the mobile carts and the three chairs identified during the survey were moved to more appropriate locations, thereby rendering the hallway in question free and clear of any obstructions.The Maintenance Director and all housekeeping personnel have been in-serviced on the importance of keeping the hallways free and clear of any furnishings, beds, carts, etc. that may obstruct traffic in the event of an emergency. These same staff members have been instructed to immediately address any such concerns noted in the future.Additionally, the facility has added	

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			another line item to our weekly Preventative Maintenance (PM) schedule that reminds our Maintenance Director to check facility hallways for any potential obstructions, and subsequently, to bring any such observations/concerns to the attention of the facility's Safety Committee for further review, in-servicing, and/or counseling, as necessary. The results of these walk-throughs will be reviewed during the facility's quarterly Quality Assurance meetings to ensure ongoing compliance.	
K 0144 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Based on record review and interview, the facility failed to ensure 1 of 1	K 0144	This deficient practice has not resulted in	08/17/2016

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	emergency generator was allowed a 5 minute cool down period after each load test, furthermore, the facility failed to provide documentation that the transfer time for the generator was being recorded after each load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems,1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shut down. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's Weekly Generator Log on 08/15/16 at 11:30 a.m. with the Maintenance Director present, the generator log form documented the generator was tested weekly for 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test, furthermore,		negative outcomes for any residents or staff; however, as the finding states, all residents, staff, and visitors had the potential to be affected by this deficient practice.Immediately following the survey exit conference, the Maintenance Director updated the facility's Generator Log. Later that same week (i.e., on Wednesday, 8/17/16), the Director amended the format of the Log sheet to include entry spaces for both "Cool Down Time" and "Transfer Time", allowing inclusion of the necessary additional information. (Please see attached Generator Log, as amended.)Generator Logs will be completed each week by the Maintenance Director, and kept on file for review each month by	

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	there was no documentation that showed the generator transfer time being recorded following its load test. During an interview at the time of record review, the Maintenance Director confirmed the weekly generator log did not include documentation of a cool down time being recorded or the generator transfer time being recorded. 3.1-19(b)		the Administrator upon request. Information contained on the Generator Logs will be made available for review during the quarterly Quality Assurance meetings, in an effort to ensure ongoing compliance. Any issues and/or concerns noted by the Interdisciplinary team during such meetings will be promptly addressed as necessary.	
K 0000 Bldg. 02	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: 08/15/16 Facility Number: 000442 Provider Number: 155621 AIM Number: 100266510 At this Life Safety Code survey, Pine Haven Health and Rehabilitation Center	K 0000	By submitting the Plan of Correction, the facility is not admitting to the truth or accuracy of the cited deficiencies or allegations. The facility reserves the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our	

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	was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. The Stocker Addition II was surveyed with Chapter 18 New Health Care Occupancies. This portion of the facility was one story and determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in corridors, areas open to the corridors, and all resident sleeping rooms. The facility has a capacity of 113 and had a census of 65 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except, two detached buildings used for facility storage. Quality Review completed on 08/18/16 - DA		regulatory obligations. The facility requests the Plan of Correction be considered our allegation of compliance, effective on or before August 29th, 2016, to the cited deficiencies of the Life Safety Code Recertification and State Licensure Survey with an exit date of August 15th, 2016.	
K 0050 SS=C Bldg. 02	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			

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PINE HAVEN HEALTH AND REHABILITATION CENTER	3400 STOCKER DR EVANSVILLE, IN 47720

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	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 fire drills were held at varied times for 1 of 3 employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drills on 08/15/16 at 10:45 a.m. with the Maintenance Director present, three of four, third shift (night) fire drills were performed between 5:45 a.m. and 6:30 a.m. During an interview at the time of record review, the Maintenance Director acknowledged the times the third shift fire drills were performed and agreed the times were not varied enough. 3-1.19(b)	K 0050	This deficient practice has not resulted in any negative outcomes for any residents or staff; however, as the finding states,all residents had the potential to be affected by this deficient practice. In order to ensure that the times for the facility's fire drills vary enough to keep staff, residents, and visitors alert and prepared in the event of a fire, the Fire Drill Tracking Tool has been updated to include pre-determined dates and times for all future drills. This update will ensure varied times and days are being tested for each and every shift, including both weekend days. (Please see attached Fire Drill Tracking Tool.) The Fire Drill Tracking Tool will be routinely completed by the Maintenance Director and be reviewed monthly with the Administrator to ensure ongoing compliance. Any issues noted during this review will be promptly addressed.	08/16/2016
K 0051 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems			

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	and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6			
	Based on observation and interview, the facility failed to ensure 1 of 17 manual fire alarm boxes was readily accessible. NFPA 72, The National Fire Alarm Code, 2-8.2.1 states manual fire alarm boxes shall be distributed throughout the protected area so that they are unobstructed, readily accessible, and located in the path of exit from the area. This deficient practice affect all residents, as well as staff and visitors in the facility. Findings include: Based on observation on 08/15/16 at	K 0051	This apparently deficient practice has not resulted in negative outcomes for any residents or staff; however, as the finding states, all residents (especially those on the Stocker I and II units)had the potential to be affected by this presumably deficient practice. As part of the effort to attain compliance, the facility's Maintenance Director and Administrator met with representatives from the facility's fire and safety contractor (i.e., Priority One Fire and Security) to discuss the placement of the manual fire alarm pull station located on the wall behind the	08/29/2016

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	12:50 p.m. during a tour of the facility with the Maintenance Director, the manual fire alarm pull station at the smoke barrier doors between Stocker I and Stocker II cross corridor between rooms 311 and 400 was located on the wall behind the east side smoke barrier door while held open with the magnetic door holder. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)		smoke barrier doors near Room #311. Upon further research, it was determined that the fire alarm box referenced in the survey finding had been placed near what was, originally, an exit door (i.e., prior to the construction of the Stocker II addition in 2005). However, as part of the construction of the Stocker II unit, this exit door was converted to its current function as a set of smoke barrier doors; therefore, a determination has been made that this manual fire alarm pull station can be safely eliminated entirely. Priority One Fire and Security has confirmed that sufficient fire alarm boxes have been installed at the appropriate places in the facility to ensure both safety and compliance with applicable regulatory requirements. Priority One will continue to do quarterly assessments of the facility's fire alarm stations and smoke detection systems to ensure all equipment and systems are operational and reliable. The Maintenance Director will retain copies of the reports resulting from all such contractor assessments.	
K 0062 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5			

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	Based on record review, observation and interview; the facility failed to ensure 1 of 1 private fire hydrants was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected and the necessary corrective action shall be taken. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of preventive maintenance records in the Fire and Sprinkler book on 08/15/16 at 11:10 a.m. with the Maintenance Director present, there was no documentation to show the facility's one fire hydrant has had an annual inspection since 05/11/15. Based on interview at the time of record review, the Maintenance Director said the facility's one fire hydrant has not been inspected during the past twelve months. Based on observation between 11:45 p.m. and 2:00 p.m. during a tour of the facility with the Maintenance Director, there was one private fire hydrant on the facility's	K 0062	This deficient practice has not resulted in negative outcomes for any residents or staff; however, as the finding states, all residents had the potential to be affected by this deficient practice.Immediately following the survey exit conference, the Maintenance Director contacted the facility's local contractor to schedule a prompt inspection of the private fire hydrant. This contractor (i.e., Southwest Sprinkler) is now scheduled to inspect the fire hydrant (with the assistance of the Evansville Water and Sewer Utility) prior to the end of August, 2016.Additionally, the facility has added another line item to the monthly Preventative Maintenance (PM) schedule to remind the	08/31/2016

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	property. 3.1-19(b)		Maintenance Director to monitor the fire hydrant inspection record each month. When monitoring indicates that the facility is within three (3) months of the next inspection “due date”, a call will be placed to Southwest Sprinkler to schedule the required inspection visit.Prior to the facility’s regularly scheduled quarterly Quality Assurance meetings, the Maintenance Director will submit to the Administrator copies of all PM schedules to ensure ongoing compliance with the requirement to annually inspect the fire hydrant in question.	
K 0072 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD 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. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with			

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	7.1.10. 18.2.1, 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 10 corridor means of egress was continuously maintained free of obstructions. This deficient practice could affect up to 12 residents, as well as staff and visitors in the Stocker I and Stocker II 300 and 400 west corridor. Findings include: Based on an observation on 08/15/16 at 12:52 p.m. and again at 1:45 p.m. during a tour of the facility with the Maintenance Director, the Stocker I and Stocker II 300 and 400 hall west corridor had three wheeled carts and three chairs stored in the corridor. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)	K 0072	This deficient practice has not resulted in negative outcomes for any residents or staff; however, as the finding states,any residents, staff, or visitors located on the west corridor of the Stocker I or II units during an emergency had the potential to be affected by this deficient practice.Within hours of this concern being brought to the attention of the Maintenance Director, the mobile carts and the three chairs identified during the survey were moved to more appropriate locations, thereby rendering the hallway in question free and clear of any obstructions.The Maintenance Director and all housekeeping personnel have been in-serviced on the importance of keeping the hallways free and	08/16/2016

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			clear of any furnishings, beds, carts, etc. that may obstruct traffic in the event of an emergency. These same staff members have been instructed to immediately address any such concerns noted in the future.Additionally, the facility has added another line item to our weekly Preventative Maintenance (PM) schedule that reminds our Maintenance Director to check facility hallways for any potential obstructions, and subsequently, to bring any such observations/concerns to the attention of the facility's Safety Committee for further review, in-servicing, and/or counseling, as necessary. The results of these walk-throughs will be reviewed during the facility's quarterly Quality	

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			Assurance meetings to ensure ongoing compliance.	
K 0144 SS=C Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Based on record review and interview, the facility failed to ensure 1 of 1 emergency generator was allowed a 5 minute cool down period after each load test, furthermore, the facility failed to provide documentation that the transfer time for the generator was being recorded after each load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems,1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shut down. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.	K 0144	This deficient practice has not resulted in negative outcomes for any residents or staff; however, as the finding states, all residents, staff, and visitors had the potential to be affected by this deficient practice.Immediately following the survey exit conference, the Maintenance Director updated the facility's Generator Log. Later that same week (i.e., on Wednesday, 8/17/16), the Director amended the format of the Log sheet to include entry spaces for both "Cool Down Time" and	08/17/2016

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	Findings include: Based on review of the facility's Weekly Generator Log on 08/15/16 at 11:30 a.m. with the Maintenance Director present, the generator log form documented the generator was tested weekly for 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test, furthermore, there was no documentation that showed the generator transfer time being recorded following its load test. During an interview at the time of record review, the Maintenance Director confirmed the weekly generator log did not include documentation of a cool down time being recorded or the generator transfer time being recorded. 3.1-19(b)		"Transfer Time", allowing inclusion of the necessary additional information. (Please see attached Generator Log, as amended.)Generator Logs will be completed each week by the Maintenance Director, and kept on file for review each month by the Administrator upon request. Information contained on the Generator Logs will be made available for review during the quarterly Quality Assurance meetings, in an effort to ensure ongoing compliance. Any issues and/or concerns noted by the Interdisciplinary team during such meetings will be promptly addressed as necessary.	