STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 01 B. WING	07/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ROCHESTER	827 W 13TH ST ROCHESTER, IN 46975

(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: 07/31/17 Facility Number: 000325 Provider Number: 155379 AIM Number: 100274300 At this Life Safety Code survey, Life Care Center of Rochester 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 one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery powered smoke detectors in the resident rooms. The facility has a capacity of 141 and had a census of 67 at the time of this survey.	K 0000	08/25/2017 completion date	

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. The facility had one detached garage used for facility storage which was not sprinklered. Quality Review completed on 08/04/17 - DA			
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 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 4 corridors from obstructions per 19.2.3.5. LSC 19.2.3.4.5 requires aisles, corridors, and ramps to be arranged to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers. This deficient practice could affect staff and up to 19 residents. Findings include: Based on observation with the Director of	K 0211	K211 NFPA 101 Means of Egress - General All items were removed from aisles, passageways, corridors, exit discharges, exit locations immediately from all noted areas. All facility residents had the potential to be affected. Maintenance Director or Designee to monitor 5 days a week for 4 weeks, then once weekly for 4 weeks, then monthly for compliance. Safety Meeting to evaluate need for continued monitoring. Completion date – 08/25/2017	08/25/2017

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	Maintenance on 07/31/17 at 11:05 a.m. then again at 1:55 p.m., a 50 gallon paper shred container was in the corridor by Room 109. Then again, a fan was in the corridor outside resident room 224. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned condition and was not sure why the paper shred container was stored there. 3.1-19(b)			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements			

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	are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation, record review, and interview, the facility failed to ensure 1	K 0222	**K222 NFPA 101 Egress Doors** Immediate all doors were audited for the proper code to be used as	08/25/2017

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	of 9 entrance/exits had a correct code posted. LSC 19.2.2.2.3 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 at least 9 residents. Findings include: Based on observation with the Director of Maintenance on 07/31/17 at 11:23 a.m., the Front Lobby 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. The code posted stated "MDY." When tested, the magnetic hold down device did not unsecured the door. Based on an interview at the time of observation, the Director of Maintenance confirmed the wrong code was posted and needs to be		MMYYYY*. All doors tested immediate for proper code. All facility residents had the potential to be affected. Maintenance Director or Designee to monitor 5 days a week for 4 weeks, then once weekly for 4 weeks, then monthly for compliance. Safety Meeting to evaluate need for continued monitoring. Completion date – 08/25/2017	

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	updated. 3.1-19(b)			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 1. Based on observation and interview, the facility failed to ensure the emergency lighting of at least 1-1/2-hour duration for 9 of 9 exit discharge means of egress was provided. This deficient practice could affect all occupants. Findings include: Based on observation with the Director of Maintenance on 07/31/17 between 10:40 a.m. and 3:26 p.m., all exit discharges were provided with light fixtures but based on interview at the time of observation, the Director of Maintenance was unable to confirm if the exterior light fixture was provided with backup power by the generator or a battery. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain 1 of 1 battery operated emergency light in the	K 0291	K291 NFPA 101 Emergency Lighting Maintenance Director ordered and replaced with a new lightening unit, tested said unit. All facility residents had the potential to be affected. Maintenance Director or Designee to monitor 5 days a week for 4 weeks, then once weekly for 4 weeks, then monthly for compliance. Safety Meeting to evaluate need for continued monitoring. Completion date – 08/15/2017	08/15/2017

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	Boiler room. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect staff only. Findings include: Based on observation with the Director of Maintenance on 07/31/17 at 12:58 p.m., the battery operated emergency light in the Boiler room failed to illuminate when tested. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned condition. 3.1-19(b)			
K 0321 SS=E 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			

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	(with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved 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 Mechanical room, 1 of 1 Central Supply Room, and 1 of 1 Soiled Utility room in accordance of 19.3.2. This deficient practice could affect staff and at least 13 residents. Findings include:	K 0321	K321 Hazardous Areas – Enclosure Mechanical room corridor door had a new self-closing device ordered. Central Supply room latch was adjusted immediately for safety and latching. Soiled Utility room latch door handle was replaced 08/01/2017. All facility residents had the potential to be affected. Maintenance Director or Designee	08/25/2017

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	Based on observation with the Maintenance Director on 07/31/17 between 10:40 a.m. and 3:26 p.m., the following was discovered: a) the fuel-fire Mechanical room corridor door did not have a self-closing device installed b) the Central Supply room was greater than 50 square feet containing combustible materials. When the corridor door was tested, the door self-closed but failed to latch. c) the Soiled Utility room contained two separate 50 gallons containers. When the corridor door was tested, the door self-closed but failed to latch into the frame. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition. 3.1-19(b)		to monitor 5 days a week for 4 weeks, then once weekly for 4 weeks, then monthly for compliance. Safety Meeting to evaluate need for continued monitoring. All Completions date – 08/25/2017	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily			

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	available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 14.4.5 Testing Frequencies. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Maintenance on 07/31/17 between 10:40 a.m. and 3:26 p.m., no fire alarm sensitivity test was available for review. Based on interview at the time of record review, the Director of Maintenance acknowledged the aforementioned condition and confirmed no other documentation was available for review. 3.1-19(b)	K 0345	K345 NFPA 101 Fire Alarm System – Testing and Maintenance Sensitivity testing had been completed for facility in a timely manner. Maintenance Director was not able to provide the documentation in a timely manner. Sensitivity testing paperwork was received and had a testing date of 01/21/2016 and will be scheduled for every other year inspection. All facility residents had the potential to be affected. All battery smoke alarms will be tested and inspected weekly. When a negative battery test is resulted, immediate replacement of battery shall be changed out. Maintenance Director or Designee to monitor 5 days a week for 4 weeks, then once weekly for 4 weeks, then monthly for compliance. Safety Meeting to evaluate need for continued monitoring. Completion date – 08/25/2017	08/25/2017

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	2. Based on record review, interview and observation; the facility failed to ensure 1 of 1 documentation for the preventative maintenance of battery operated smoke alarms in client rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on record review with the Director of Maintenance on 07/31/17 at 10:05 a.m., no documentation for battery replacement of battery operated smoke alarms was available for review. Based on observation and the time of record review, the Director of Maintenance acknowledged the aforementioned conditions.			
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked			

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	b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Maintenance on 07/31/17 at 10:00 a.m., the sprinkler system was inspected quarterly. The monthly control valves and monthly wet system gauge inspection was not available prior to January 2017. Based on interview at the time of record review, the Director of Maintenance acknowledged the lack of documentation. 3.1-19(b)	K 0353	K353 NFPA 101 Sprinkler System – Maintenance and Testing New Maintenance Director had started in 01/16/2017 and all sprinkler testing has been completed from this time forward. All monitoring and testing prior to 01/16/2017 records could not be found. Maintenance Director will electronically input sprinkler gauge pressure testing for permanent record retrieval and retention for record keeping. All facility residents had the potential to be affected. Maintenance Director or Designee to monitor 5 days a week for 4 weeks, then once weekly for 4 weeks, then monthly for compliance. Safety Meeting to evaluate need for continued monitoring. Completion date – 08/25/2017	08/25/2017

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K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. 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 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the	K 0363	K363 NFPA 101 Corridor – Doors	08/25/2017

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	facility failed to maintain protection of corridor doors in 1 of 4 corridors in accordance of 19.3.6.3. This deficient practice could affect staff and at least 5 residents. Findings include: Based on observation with the Director of Maintenance on 07/31/17 at 12:24 p.m., resident room 322 failed to latch into the frame when tested. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned condition. 3.1-19(b)		Director of Maintenance corrected the deficiency door immediately on 08/02/2017. A full facility audit to be conducted and completed by 08/25/2017 to ensure that all doors latch properly. All facility residents had the potential to be affected. Maintenance Director or Designee to monitor 5 days a week for 4 weeks, then once weekly for 4 weeks, then monthly for compliance. Safety Meeting to evaluate need for continued monitoring. Completion date – 08/25/2017	
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	K 0372	K372 NFPA 101 Subdivision of Building Spaces – Smoke Barrier	08/02/2017

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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
	caused by the passage of wire and/or conduit through 4 of 6 smoke barrier walls were protected to maintain the 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 8 residents. Findings include: Based on observations with the Director of Maintenance on 07/31/17 at 2:47 p.m., a three quarter inch penetration in the 300 Hall smoke barrier. Based on interview at the time of observation, the Director of Maintenance acknowledged each aforementioned condition and provided the measurement. 3.1-19(b)		Director of Maintenance immediately repaired the deficient are with recommended fire rated caulk. All facility residents had the potential to be affected. Maintenance Director or Designee to further inspect area(s) for further deficiencies and monitor 5 days a week for 4 weeks, then once weekly for 4 weeks, then monthly for compliance. Safety Meeting to evaluate need for continued monitoring. Completion date – 08/02/2017	
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 6 of 6 electrical	K 0511	K511 NFPA 101 Utilities – Gas and Electric Exposed wiring in an electrical box	08/22/2017

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	junction boxes observed was 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 Director of Maintenance on 07/31/17 between 12:38 p.m. and 3:10 p.m., there was exposed wiring in an electrical box without a cover in the following locations: a) fire alarm panel room b) above the ceiling tile near the Beauty Shop smoke barrier c) above the ceiling tile near the 200 Hall smoke barrier d) above the ceiling tile near the South Boiler room smoke barrier e) above the ceiling tile near the resident room 314 smoke barrier f) above the ceiling tile near the Lobby smoke barrier Based on interview at the time of each		without a cover in the following locations: 1.fire alarm panel room – 4x4 cover plates replaced 08/04/2017 2.above the ceiling tile near the Beauty Shop smoke barrier – 4x4 cover plates replaced 08/22/2017 3.above the ceiling tile near the 200 Hall smoke barrier – 4x4 cover plates replaced 08/22/2017 4.above the ceiling tile near the South Boiler room smoke barrier – 4x4 cover plates replaced 08/22/2017 5.above the ceiling tile near the resident room 314 smoke barrier – 4x4 cover plates replaced 08/04/2017 6.above the ceiling tile near the Lobby smoke barrier - 4x4 cover plates replaced 08/22/2017 All facility residents had the potential to be affected. Maintenance Director or Designee to further inspect area(s) for further deficiencies and monitor 5 days a week for 4 weeks, then once weekly for 4 weeks, then monthly for compliance. Safety Meeting to evaluate need for continued monitoring. Completion date – 08/22/2017	

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	observation, the Director of Maintenance acknowledged each aforementioned condition. 3.1-19(b)			
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 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 fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire	K 0711	K711 NFPA 101 Evacuation of Relocation Plan The Emergency phone call to fire department telephone number was updated and placed as the first Emergency contact call to make during an evacuation, as updated in the Emergency Manual. All facility residents had the potential to be affected. Maintenance Director or Designee to audit 5 days a week for 4 weeks, then once weekly for 4 weeks, then monthly for compliance. Safety Meeting to evaluate need for continued monitoring. Completion date – 08/25/2017	08/25/2017

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	(6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on a record review and interview on 07/31/17 at 3:00 p.m., the Director of Maintenance acknowledged the "Fire Plan Policy and Fire Procedures" did not address (3) Emergency phone call to fire department. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills 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. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 1. Based on record review and interview,	K 0712	K712 NFPA 101 Fire Drills	08/25/2017

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	the facility failed to conduct quarterly fire drills for 2 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the "Fire Drills" form with the Director of Maintenance on 07/31/17 at 9:50 a.m., there was no documentation for a first shift fire drill in the fourth quarter of 2016. There was no documentation for a second shift fire drill in the first quarter of 2017. Additionally, no signatures were on the fire drill documentation. Based on interview at the time of record review, the Director of Maintenance acknowledged the aforementioned condition. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to ensure 12 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. This deficient practice affects all residents in the facility		New Maintenance Director had started in 01/16/2017 and all prior fire drill monitoring and testing prior to 01/16/2017 records could not be found. Maintenance Director will electronically input fire drills and testing for permanent record retrieval and retention for record keeping. All facility residents had the potential to be affected. Maintenance Director or Designee to audit 5 days a week for 4 weeks, then once weekly for 4 weeks, then monthly for compliance. Safety Meeting to evaluate need for continued monitoring. Completion date – 08/25/2017	

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	as well as staff and visitors. Findings include: Based on record review of titled "Fire Drills" with the Director of Maintenance on 07/31/17 at 9:50 a.m., the documentation for the drills for the past twelve months lacked verification of the transmission of the signal for drills. Based on interview at the time of record review, the Director of Maintenance confirmed only that he contacted SafeCare to take the system off of test. 3.1-19(b) 3.1-51(c)			
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. * 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	K 0753	K753 NFPA 101 Combustible	08/25/2017

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	facility failed to ensure 1 of 1 Central Supply Manager's office 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 only. Findings include: Based on observation with the Director of Maintenance on 07/31/17 at 11:27 a.m., the Central Supply Manager's office contained a candle with a wick. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned condition and confirmed there was a wick in the candle. 3.1-19(b)		Decorations Maintenance Director immediately removed the unlit decorative candle and disposed of it. Maintenance Director also inspected the entire facility for further combustible items. No other combustible items were found. All facility residents had the potential to be affected. All Residents and family members are being advised that candles are not permitted in the facility through printed materials sent with billing statements and facility admissions coordinator upon admission. The housekeeping supervisor also adapted the daily housekeeping checklists to include the monitoring of resident rooms for the presence of candles, advised housekeepers to remove them if any are found and to alert the Executive Director or Designee. Maintenance Director or Designee to audit and inspect for combustible items, 5 days a week for 4 weeks, then once weekly for 4 weeks, then monthly for compliance. Safety Meeting to evaluate need for continued monitoring. Completion date – 08/25/2017	
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			

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	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 2 of 2 power strip according to 9.1.2. 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 at least 6 residents. Findings include:	K 0920	K920 NFPA 101 Electrical Equipment – Power Cords and Extension Cords Oxygen concentrator in resident room was removed immediately, Physicians Office Medication room 2 refrigerators, the entire area was changed around to remove the surge protectors and direct plug both refrigerators into wall, Maintenance office air conditioner was immediately unplugged and air conditioner removed from this area of building. All facility residents had the potential to be affected. Maintenance Director or Designee to audit 5 days a week for 4 weeks, then once weekly for 4 weeks, then	08/25/2017

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	Based on observation with the Director of Maintenance on 07/31/17 at 11:40 a.m. then again at 12:25 p.m., a power strip was powering an oxygen concentrator in resident room 212. Then again, a power strip was installed at the head of a bed in resident room 324. Based on interview at the time of observation, the Director of Maintenance was unable to provide UL 60601-1 documentation for the permanently installed power strip in a patient care area and confirmed the surge protectors were within six feet of a patient care location. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 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 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 only. Findings include: Based on observation with the Director of		monthly for compliance. Safety Meeting to evaluate need for continued monitoring. Completion date – 08/25/2017	

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	Maintenance on 07/31/17 at 11:55 a.m. then again at 2:00 p.m., a surge protector was powering two separate refrigerators in the Physicians Office Medication room. Then again, a surge protector was powering a air conditioner in the Maintenance office. Based on interview at the time of each observation, the Director of Maintenance acknowledged each aforementioned condition. 3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are			

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	not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect at least 14 residents.	K 0923	K923 NFPA 101 Gas Equipment – Cylinder and Container Storage Resident room 300 had family bring in his own oxygen cylinder for usage that was empty. Director of Maintenance informed resident of the improper usage of such cylinder in a facility setting and immediately removed the cylinder and notified family to pick cylinder up to remove from facility. All facility residents had the potential to be affected. Maintenance Director or Designee to audit 5 days a week for 4 weeks, then once weekly for 4 weeks, then monthly for compliance. Safety Meeting to evaluate need for continued monitoring. Completion date – 08/01/2017	08/01/2017

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	Findings include: Based on observation with the Director of Maintenance on 07/31/17 at 11:56 a.m., an oxygen cylinder was freestanding in resident room 300. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned condition and did not know where the oxygen tank came from. 3.1-19(b)			