STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING 01 B. WING	04/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE TOLLESTON PARK	2350 TAFT ST GARY, IN 46404

(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: 04/18/17 Facility Number: 008505 Provider Number: 155580 AIM Number: 200064830 At this Life Safety Code survey, Aperion Care Tolleston Park 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 with a partial basement was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors. Battery powered smoke detectors are located in the North and South wing resident rooms; the PCU resident rooms	K 0000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	are equipped with hard wired smoke detectors. The facility has the capacity for 180 and had a census of 118 at the time of this survey. All areas where the residents have customary access were sprinklered. A detached wood equipment storage shed was unsprinklered. Quality Review completed on 04/20/17 - DA			
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			

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	safety needs of the patient are used, all of the Clinical or Security Locking requirements 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	K 0222	**K222 NFPA 101 EGRESS**	05/05/2017

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	interview, the facility failed to ensure 1 of 1 Front Entrance exits had a code posted in accordance with 19.2.2.2.5.1. LSC 19.2.2.2.5.1 says door locking arrangements shall be permitted where the clinical needs of patients require specialized security measures or where patients pose a security threat, provided that staff can readily unlock doors at all times in accordance with 19.2.2.2.6. LSC 19.2.2.2.6(1)(c) states provisions shall be made for the rapid removal of occupants by other such reliable means available to the staff at all times. This deficient practice could affect staff and up to 26 residents. Findings include: Based on observation with the Maintenance Director on 04/18/17 at 10:45 a.m., the Front Entrance contained a magnetic lock with a keypad. No code was posted. Based on an interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed that residents did not have a special need for the additional security measures. 3.1-19(b)		**DOORS** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · The exit code has been added to the magnetic lock keypad. There were no residents cited in regard to this regulation.	

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			2) How the facility identified other residents: · Staff and residents that reside at the community have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Department changes the magnetic lock code monthly and will ensure that code is present on all of the keypads. The Maintenance Director will be re-educated on Exit Access Codes by the Executive Director/designee by 5/5/17. · The Maintenance Director is responsible for compliance. **4) How the corrective actions**	

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			will be monitored: · An Environmental QAPI tool will be utilized weekly x 4 and monthly thereafter, to monitor compliance with exit codes. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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 (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			

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	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 hot oil popcorn popper in the Activity room. This deficient practice could affect staff and up to 10 residents. Findings include: Based on observation with the Maintenance Director on 04/18/17 at 12:18 p.m., the Activity room contained a hot oil popcorn popper. One of the three Activities corridor door failed to latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)	K 0321	**K321 NFPA 101 HAZARDOUS AREAS- ENCLOSURE** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it*	05/05/2017

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			is required by the provisions of federal and state law. **1) Immediate actions taken for those residents identified:** · There were no residents cited in regard to this regulation. **2) How the facility identified other residents:** · Staff and residents that reside at the community have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Activity Room corridor door latch was repaired immediately. · Interior corridor doors are checked monthly and	

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			documented in the Preventative Maintenance Manual. · The Maintenance Department will be re-educated on the Preventative Maintenance Program by the Executive Director/designee by 5/5/17. · The Maintenance Director is responsible for compliance. **4) How the corrective actions will be monitored:** · The Executive Director will review the Preventative Maintenance Manual monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for			

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	Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility failed to ensure 1 of 1 Activities kitchen was provided with a fire suppression system per NFPA 96. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 4.1.1 requires cooking equipment that produces grease-laden vapors shall be equipped with an exhaust system that complies with all the equipment and performance requirements of this standard. This deficient practice affects staff and up to 10 residents. Findings include: Based on observation with the	K 0324	**K324 NFPA 101 COOKING FACILITIES** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or*	05/05/2017

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	Maintenance Director on 04/18/17 at 12:18 p.m., the Activities kitchen had a residential stove without a fire suppression system. A quarter empty bottle of vegetable oil was discovered in the cabinets. Based on interview at the time of observation, the Activity Director confirmed that vegetable oil was used to cook "greens" for certain celebrations. The Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)		*conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · There were no residents cited in regard to this regulation. **2) How the facility identified other residents:** · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:**	

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			· Activities staff will be re-educated on the use of the Activity Room Stove by the Executive Director/designee by 5/5/17. · The Activity Director is responsible for compliance. **4) How the corrective actions will be monitored:** · An Environmental QAPI tool will be utilized monthly to monitor compliance with proper smoke barrier walls. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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.			

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	Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ 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 Maintenance Director on 04/18/17 at 11:23 a.m., no documentation for the sprinkler system gauge and control valve inspections was available prior to 01/04/17. Based on interview at the time of record review, the Maintenance	K 0353	**K 353 NFPA 101 SPRINKLER SYSTEM – MAINTENANCE AND TESTING** **1) Immediate actions taken for those residents identified:** · There were no residents cited in regard to this regulation. **2) How the facility identified other residents:** · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice.	05/05/2017

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	Director acknowledged the aforementioned condition. 3.1-19(b)		**3) Measures put into place/ System changes:** · Sprinkler System Gauge and Control Valve inspections are completed weekly and documented on the Sprinkler System Check Log by the Maintenance Department. · The Maintenance Department will be re-educated on the Preventative Maintenance Program by the Executive Director/designee by 5/5/17. · The Maintenance Director is responsible for compliance. **4. How the corrective actions will be monitored:** · The Sprinkler Check Log is part of the	

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			Preventative Maintenance Manual. The Executive Director will review the Preventative Maintenance Manual monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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			

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	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 facility failed to ensure 1 of 1 resident room 214 had no impediment to closing. This deficient practice could affect staff and up to 30 residents. Findings include: Based on observation with the Maintenance Director on 04/18/17 at 11:51 a.m., resident room 214 corridor door was impeded from closing by a resident's bed crank. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)	K 0363	**K363 NFPA 101 CORRIDOR DOORS** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared*	05/05/2017

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			and/or executed solely because it is required by the provisions of federal and state law. **1) Immediate actions taken for those residents identified:** · The bed cranks were lowered and the door was obstructed immediately. **2) How the facility identified other residents:** · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · Beds will not be placed against the wall near a door. · Angel Rounds are made	

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			daily by managers which include the monitoring of bed placement. The manager findings will be documented on the Daily Manager Rounds sheet and reviewed at the daily meetings. · The DON is responsible for compliance. · Employees will be re-educated on bed positioning by the DON/designee by 5/5/17. **4) How the corrective actions will be monitored:** · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke			

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	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 10 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 84 residents. Findings include: Based on observations with the Maintenance Director on 04/18/17 between 12:50 p.m. and 1:29 p.m., the following unsealed penetrations were discovered: a) three separate one inch penetrations in the Dining Room attic smoke barrier b) one quarter inch gap on top of conduit	K 0372	**K372 NFPA 101 SUBDIVISION OF BUILDING SPACES – SMOKE BARRIER** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	05/05/2017

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	in the resident room 209 smoke barrier above the drop ceiling c) a three quarter inch gap around wires in the resident room 214 smoke barrier above the drop ceiling d) a three quarter inch gap inside conduit and a quarter inch gap between conduit in the resident room 329 smoke barrier above the drop ceiling e) a half inch by two inch gap around HVAC in the resident room 329 attic smoke barrier Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition and provided the measurements. 3.1-19(b)		*federal and state law.* **1) Immediate actions taken for those residents identified:** · There were no residents cited in regard to this regulation. · The Dining Room penetrations have been repaired. · The gap in the conduit by Room 209 has been repaired. · The gap around the wires by Room 214 has been repaired. · The gaps in the conduit by Room 329 have been repaired. · The gap around the HVAC in the attic by Room 329 have been repaired. **2) How the facility identified other residents:** · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice.	

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			3) Measures put into place/ System changes: · Outside contractors will be educated, prior to completing services on the building, about proper fire wall penetrations. The Maintenance Director/designee will inspect for penetrations prior to job completion. · The Maintenance Director is responsible for compliance. **4) How the corrective actions will be monitored:** · An Environmental QAPI tool will be utilized monthly to monitor compliance with proper smoke barrier walls. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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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, the facility failed to conduct quarterly fire drills for 1 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 Drill Report" form with the Maintenance Director on 04/18/17 at 10:11 a.m., there was no documentation for a first shift fire drill in the third quarter of 2016. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.	K 0712	**K712 NFPA 101 FIRE DRILLS** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared*	05/05/2017

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	3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 3 of 4 quarters. This deficient practice affects all occupants. Findings include: Based on record review of the "Fire Drill Report" form with the Maintenance Director on 04/18/17 at 10:11 a.m., three sequential second shift fire drills took place between 3:30 a.m. and 3:55 p.m. for three of the last four quarters. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b) 3.1-51(c)		*and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · There were no residents cited in regard to this regulation. **2) How the facility identified other residents:** · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · Fire drills will be completed quarterly on each shift and documented on the Fire Frill Evaluation Worksheet. · Fire drills will be completed at unexpected times each	

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			quarter. · The Maintenance Director is responsible for compliance. **4) How the corrective actions will be monitored:** · Fire Drills are recorded in the Preventative Maintenance Manual. The Executive Director will review the Preventative Maintenance Manual monthly. · The results of these reviews will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0741 SS=D Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with			

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	signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for staff and residents was maintained in accordance with 19.7.4. LSC 19.7.4 requires ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. Metal containers with a self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas were smoking is permitted. This deficient practice could affect staff and up to 2 residents. Findings include:	K 0741	**K741 NFPA 101 SMOKING REGULATIONS** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the*	05/05/2017

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	Based on observations with the Maintenance Director on 04/18/17 at 11:37 p.m., there were at least 30 cigarette butts in the trash with other combustible materials in the smoking area. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)		*truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · There were no residents cited in regard to this regulation. **2) How the facility identified other residents:** · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · A metal container with a self-closing cover has been added to the approved smoking	

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			area. · The metal container will be emptied by the Maintenance Department weekly. · The Maintenance Director if responsible for compliance. **4) How the corrective actions will be monitored:** · An Environmental QAPI tool will be utilized monthly to monitor compliance with proper smoke barrier walls. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a			

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	room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7			
	Based on observation and interview, the facility failed to ensure clean recycling waste near 1 of 1 North Nurses' Station was maintained in accordance with 19.7.5.7.2. LSC 19.7.5.7.2(4) requires containers for combustibles shall be labeled and listed as meeting the requirements of FM Approval Standard 6921, Containers for Combustible Waste, however, such testing, listing, and labeling shall not limited to FM Approvals. This deficient practice could affect staff and at least 10 residents. Findings include: Based on observation with the Maintenance Director on 04/18/17 at 11:01 a.m., there were two large paper collection containers next to each other at the North Nurse's station. Based on	K 0754	**K754 NFPA 101 SOILED LINEN AND TRASH CONTAINERS** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it*	05/05/2017

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	interview at the time of observation, the Maintenance Director estimated the two containers equal 80 gallons and was unable to confirm a container listing. 3.1-19(b)		*is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · There were no residents cited in regard to this regulation. **2) How the facility identified other residents:** · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · One of the clean recycling waste bins has been removed from the North Unit nurses station. · Shredding service provider will provide label and listed as meeting the requirements of FM	

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			Approval Standard 6921. · The Maintenance Director is responsible for compliance. **4) How the corrective actions will be monitored:** · An Environmental QAPI tool will be utilized monthly to monitor compliance with proper smoke barrier walls. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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			

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	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 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 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 up to 24 residents. Findings include: Based on observation with the Maintenance Director on 04/18/17 at 11:50 a.m., a surge protector was	K 0920	**K920 NFPA ELECTICAL EQUIPMENT – POWER CORDS AND EXTENS** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The*	05/05/2017

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	powering an IV and a bed in resident room 211. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 North Nurses' Station Pantry was provided with a ground fault circuit interrupter (GFCI) protection against electric shock. LSC sections 9.1.2 requires all electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens where the receptacles are intended to serve the countertop surfaces. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Director on 04/18/17 at 10:54 a.m., the North Nurses' Station		*plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · There were no residents cited in regard to this regulation. **2) How the facility identified other residents:** · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The surge protector in Room 211 has been removed. · The GFCI receptacle was been replaced in the North Unit Pantry.	

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	155580	A. BUILDING 01 B. WING	04/18/2017

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	Pantry had one receptacle within three feet of the hand sink. When the GFCI tester button was pressed, power was not interrupted on the GFCI receptacle. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)		· Staff will be educated on the use of surge protectors by the Maintenance Director/designee by 5/5/17. · Angel Rounds are made daily by managers which include the monitoring of surge protectors. The manager findings will be documented on the Daily Manager Rounds sheet and reviewed at the daily meetings. · The Maintenance Director is responsible for compliance. **4) How the corrective actions will be monitored:** · An Environmental QAPI tool will be utilized monthly to monitor compliance with proper smoke barrier walls. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0927 SS=D	NFPA 101 Gas Equipment - Transfilling Cylinders			

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Bldg. 01	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 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 North transfill room used for transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire-resistive construction. This deficient practice could affect staff only. Findings include: Based on an observation at the time of interview with the Maintenance Director on 04/18/17 at 11:10 a.m., the North transfill room had very little space to enter and close the door. Based on interview at the time of observation, two staff members at the Nurse's station confirmed that sometimes liquid oxygen containers have to be out of the transfill room and into the shower room to transfill in the room. Additionally, staff	K 0927	**K927 NFPA 101 GAS EQUIPMENT – TRANSFILLING CYLINDERS** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	05/05/2017

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	confirmed that some staff transfill with the transfill door propped open with their leg. Maintenance Director acknowledged the aforementioned condition and confirmed the room does not provide much standing room area. 3.1-19(b)		*federal and state law.* **1) Immediate actions taken for those residents identified:** · There were no residents cited in regard to this regulation. **2) How the facility identified other residents:** · All residents, staff and visitors have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The freestanding oxygen cylinders have been removed from the community. · Nursing staff will be educated on oxygen storage and Transfilling of oxygen cylinders by the Maintenance	

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			Director/designee by 5/5/17. **4) How the corrective actions will be monitored:** · An Environmental QAPI tool will be utilized monthly to monitor compliance with proper smoke barrier walls. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0531 Bldg. 02	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			

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	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 record review, interview and observation, the facility failed to maintain testing of 1 of 1 elevator firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency 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 record review with the Maintenance Director on 04/18/17 at 1:20 p.m., no documentation for the monthly firefighter recall testing was available prior to 01/06/17. Based on interview at the time of record review, the Maintenance Director acknowledged the lack of documentation. 3.1-19(b)	K 0531	**K531 NFPA 101 ELEVATORS** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:**	05/05/2017

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			· There were no residents cited in regard to this regulation. **2) How the facility identified other residents:** · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Firefighter Recall Testing Log for prior to 1/6/17 was located after the survey. · The Firefighter Recall Testing is completed monthly and documented on the OTIS Log of Monthly Elevator Testing Firefighter's Service. · The Maintenance Director is responsible for compliance.	

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			4) How the corrective actions will be monitored: · The Log of Monthly Firefighter's Service is part of the Preventative Maintenance Manual. The Executive Director will review the Preventative Maintenance Manual monthly. · The results of these reviews will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	