STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 01 B. WING	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	3720 N NORWOOD RD HUNTINGTON, IN 46750

(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) which resulted in Immediate Jeopardy. Survey Date: 12/08/16 and 12/09/16 Facility Number: 000463 Provider Number: 155444 AIM Number: 100290910 At this Life Safety Code survey, Norwood Health and Rehabilitation Center was not found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The building was surveyed with Chapter 19 Existing Health Care Occupancies. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridor. Battery operated smoke detectors went installed in the resident rooms. The	K 0000	This Plan of Correction is Norwood Health and Rehabilitation Center's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement of Norwood Health and Rehabilitation Center to the facts alleged or the conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. **K000** The POC for this tag has been previously submitted and accepted on 12/09/16. Due to extreme cold temperatures to start of repairs was postponed until 12/27/16. Completion is now anticipated by 01/08/17, weather permitting.)	

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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	facility has a capacity of 88 and had a census of 41 at the time of this survey. All areas where the residents have customary access were sprinklered. Areas providing facility services were sprinkled. A detached garage used for storage of maintenance equipment and parts, a detached sheds used for storage of lumber and another detached shed used for storage of kitchen equipment were not sprinkled. Immediate Jeopardy was determined to exist on 12/08/16 at 10:44 a.m. The facility failed to maintain the sprinkler system to ensure it would fully function if activated. The Immediate Jeopardy was removed on 12/09/16 at 12:20 p.m. The facility implemented a fire watch with 30 minute rounds of the building conducted by a certified fire fighter from the Andrews Volunteer Fire Department. This fire watch will last until the dry sprinkler system is repaired and flushed. Quality Review completed on 12/14/16 - DA			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall			

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	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 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			

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	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			
	The facility failed to ensure 2 of 9 exits Access-Controlled Egress Door assemblies installed in accordance with 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. This deficient practice could affect as many as 25 residents in therapy and resident lounge. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 11/09/16 from 10:20 a.m. to 12:15 p.m., the therapy and court yard exit doors were both locked and had an access-controlled key pad to unlock the	K 0222	**K222** On 12/12/16 the numerical address '3720' was added to the therapy and courtyard door. Verification of posting will be added to Maint. Dir. 6 Month PM schedule. Maint. Dir. will report compliance to QA Committee annually.	01/08/2017

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	door. The code that was posted stated the word " ADDRESS." This condition would prevent any person that did not know the address to use the aforementioned exits. Based on interview at the time of observation, this was acknowledged by the Maintenance Director at the time of the observations. 3.1-19(b)			
K 0291 SS=C 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 Based on observation and interview, the facility failed to ensure 1 of 1 generator battery backup lights were tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a	K 0291	**K291** The annual testing of the battery powered light at the generator was completed timely. Facility has copy of completed testing on file.	01/08/2017

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	minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. NFPA 110 7.3.1 states level 1 or level 2 EPS equipment shall be provided with battery-powered emergency lighting. This deficient practice could affect all residents in the facility. Findings include: Based on record review on with the Maintenance Director on 12/09/16 at 9:43 a.m. there was no documentation available for review to show a 90 minute annul test was conducted for the battery powered light at the generator. Based on an interview at the time of record review, the Maintenance Director stated the annual test was conducted but could not find the documentation. 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 (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved			

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	automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220)			
	Based on observation and interview, the facility failed to ensure the corridor door to 2 of 2 hazardous such as areas storage room over 50 square feet and rooms with fuel fired equipment, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 23 residents 100 hall. Findings include:	K 0321	**K321** The clean side door to the laundry room and the door to the nursing supply room had their hinges adjusted on 12/09/16, and now fully self-latch into the door frame. Verifying the self-closing door latch appropriately, is part of the Maint. Dir. Monthly PM schedule. Maint. Dir. will report compliance to the QA Committee quarterly.	01/08/2017

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	Based on observations during a tour of the facility with the Maintenance Director on 12/09/16 between 11:30 a.m. and 12:30 p.m., the following hazardous area rooms had doors that did not automatically latch into the frame: a) The clean side door to the laundry room, which contained full fired dryers, was equipped with a self-closing device but did not self-latch into the frame. b) The door to the nursing supply room, which contained combustible storage and measured over 50 square feet, was equipped with a self-closing device but did not self-latch into the frame. Based on interview, this was acknowledged by the Maintenance Director at the time of observations. 3.1-19(b)			
K 0347 SS=C Bldg. 01	NFPA 101 Smoke Detection Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 Based on record review, interview and observation; the facility failed to ensure documentation for the preventative	K 0347	**K347** The testing of 50 of 50 battery operated smoke alarms in resident rooms was	01/08/2017

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	maintenance of 50 of 50 battery operated smoke alarms in resident 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 residents, staff, and visitors. Findings include: Based on records review with the Maintenance Director on 12/09/16 at 9:45 a.m., there was no itemized list of resident room battery operated smoke alarms tested for functionality on a monthly basis during the past twelve months. The only documentation available was a weekly preventative maintenance on TELS with a blanketed statement that the resident room battery powered smoke alarms were tested. The form did not identify location of each smoke alarm tested and if there were any issues with each smoke alarm. Based on interview, this was acknowledged by the Maintenance Director at the time of record review. Based on observations between 10:10 a.m. and 2:00 p.m. during a tour of the facility with the Maintenance Director, battery operated smoke alarms were observed in all resident sleeping rooms.		completed timely as documented in TELS. However the TELS program does not document each room separately. An itemized manually documented detail listing will be maintained until the TELS software program is updated accordingly. The itemized listing was in place by 12/20/16. Maint. Dir. will report compliance with detailed documentation to QA Committee annually.	

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	3.1-19(b)			
K 0353 SS=F 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 _____ 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 1. Based on record review and interview, the facility failed to ensure a full hydrostatic flush was performed on 1 of 2 automatic sprinkler piping systems that were internally inspected as required by NFPA 25, 2011 edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems in Chapter 14, Obstruction Prevention. Section 14.3.2 requires systems shall be examined for internal obstructions where conditions exist that could cause obstructed piping. Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient material to	K 0353	**K353** The repair of the sprinkler system riser and valves has been contracted to Ryan Fire Protection on 12/21/16. Ryan's will be in facility to take final measurements and order parts the week of 12/26/16. Completion of work is anticipated by 01/31/17, pending appropriate weather to complete repairs. Ongoing monitoring will remain a part of the 5 Year Inspection.	01/31/2017

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	obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified personnel. Section 14.3.1 states if the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of sprinkler system inspection reports on 12/08/16 at 09:35 a.m. with the Maintenance Director and Administrator present, the Ryan Fire Protection 5 Year Internal Inspection of Sprinkler Piping and Valves dated 04/28/16 for the Dry Sprinkler System indicated "The system valve, cross main, and branch line were not in satisfactory condition and the system may need further inspection, service, or repair work to make further assessments (i.e. Flushing of the system, tested for microbiological corrosion, or partial replacement). " Furthermore, the report included the following comments: 1) "Removed 1.25" screwed cap in attic, contained heavy amounts of debris." 2) "2 hour air test was performed on the			

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	dry system and failed, more than 3 pounds in the first 20 minutes." 3) "Removed face plate off of Dry system, valve had mild to medium build up. Both the piston & clapper did not move as freely as it should." Based on interview at the time of record review, Maintenance Director stated a hydrostatic flush has not been completed or scheduled due to the price of the flush was too costly. Copies of quotes were provided pertaining to problems identified in the 04/28/16 internal pipe inspection dated 06/09/16, 09/30/16, and 10/19/16. Based on observation with the Maintenance Director and Administrator on 12/09/16 between 9:00 a.m. and 1:00 p.m. the facility implemented a fire watch conducted by a certified fire fighter. 3-1.19(b) 2. Based on record review and interview, the facility failed to ensure 2 of 2 automatic sprinkler riser systems were maintained in accordance with NFPA 25. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of sprinkler system			

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	inspection reports with the Maintenance Director and Administrator present on 12/08/16 at 09:35 a.m. and on 12/09/16 at 9:30 a.m., the Ryan Fire Protection 5 Year Internal Inspection of Sprinkler Piping and Valves dated 04/28/16 for the Wet and Dry Sprinkler System indicated the following: a) The dry riser system had mild to medium build up and the piston and clapper did not move as freely as it should. b) On the wet riser system the main control valve would not close, and the flanges, nuts, and bolts were in deteriorated condition. Based on interview at the time of record review, the Maintenance Director stated the problems stated it the report has not been fixed or scheduled to be fixed due to costs and did provide a copy of a quote to fix the problems with both risers dated 06/09/16. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure 1 of 2 automatic sprinkler piping systems was inspected every five years as required by NFPA 25, 2011 Edition, and the			

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	Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 14-2.1. NFPA 25, 14.2.1 states an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. Alternative nondestructive examination methods shall be permitted. Non-metallic pipe shall not be required to be inspected internally. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of sprinkler system inspection reports. with the Maintenance Director and Administrator present on 12/08/16 at 09:35 a.m. and on 12/09/16 at 9:30 a.m., the Ryan Fire Protection 5 Year Internal Inspection of Sprinkler Piping and Valves dated 04/28/16 for the Wet Sprinkler System indicated an internal inspection on pipes and valves of the wet sprinkler system could not be conducted due to the main control valve would not close and the deteriorated condition of the flanges and bolts. Based on an interview at the time of record			

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	review, the Maintenance Director acknowledge the inspection could not be completed due to the condition of the riser system. 3.1-19(b) 4. Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler control valves had been inspected for 12 of 12 past months. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be			

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	155444	A. BUILDING 01 B. WING	12/09/2016

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	inspected monthly. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on records review with the Maintenance Director on 12/08/16 at 9:30 a.m., there was no monthly inspection of the sprinkler system's control valves available for review. During an interview at the time of record review, the Maintenance Director acknowledged there was no written documentation available to show the sprinkler system's control valves had been inspected monthly. 3.1-19(b)			
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			

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	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 2 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. NFPA 101 2012 edition 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC 8.5. 8.5.2.2 States smoke barriers required by this code shall be continuous from outside wall to outside wall, from floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 Requires penetrations for cable, conduit, pipe, or wire...of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. This deficient practice affects 25 residents in four smoke compartments. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 12/09/16 between 10:00 a.m. and 12:30 p.m. the following smoke barrier walls had unsealed penetrations: a) in the attic of the smoke barrier wall to	K 0372	**K372** The attic smoke barrier wall to therapy and the smoke barrier wall above the ceiling tiles by room 103 were repaired on 12/20/16. Smoke barrier wall inspections will be added to the Maint. Dir. Annual PM schedule. Maint. Dir. will report compliance to the QA Committee annually.	01/08/2017

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	therapy there was an unsealed one inch penetration around wires. b) Above the ceiling tiles of the smoke barrier wall by room 103 there was an unsealed one inch hole above conduits. Based on interview at the time of observation, the Maintenance Director acknowledged and provided the measurements of the penetrations. 3.1-19(b)			
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation records review, and interview, the facility failed to maintain annual testing of 1 of 1 rolling fire door in accordance of 19.3.6.3.3. LSC 19.3.6.3.3 requires compliance with NFPA 80, Standard for Fire Doors and	K 0374	**K374** The annual testing of the rolling fire door between the kitchen and dining room was completed timely. Facility has copy of completed testing on file.	01/08/2017

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	Other Opening Protectives. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect 30 residents in the dining room. Findings include: Based on observation during a tour of the facility with Maintenance Director on 12/09/16 at 12:07 p.m., there was a rolling fire in the wall between the kitchen and dining room. Based on records review at 10:15 a.m., there was no annual inspection of the rolling fire door available for review. Based on interview at the time of records review, the Maintenance Director stated an annual was conducted but could not find the paper work. 3.1-19(b)			
K 0511 SS=E 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			

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	service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of 1 electrical light switch outlets in the 300 linen room was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect 20 residents in the 300 hall. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 12/09/16 at 11:18 a.m., the light switch cover in the 300 hall clean linen room was broken and half missing. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed that exposed wiring was visible. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical wirings in the 300 nurse ' s station was protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed	K 0511	**K511** The light switch cover plate in the 300 hall linen room was replaced on 12/12/16. The inspection of electrical light and switch plates is a part of the Maint. Dir. Monthly PM schedule. Maint. Dir. will report compliance to the QA Committee quarterly.	01/08/2017

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	so that live wiring terminals are not exposed to contact. This deficient practice could affect 20 residents in the 300 hall. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 12/09/16 at 10:48 a.m., in the 300 hall nurses station med-closet there was a conduit with exposed wires at the open end of the conduit. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed that exposed wiring was visible. 3.1-19(b)			
K 0741 SS=E 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 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			

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	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 1. Based on observation and interview; the facility failed to ensure 2 of 2 smoking areas were maintained by disposing cigarette butts in the provided metal or noncombustible containers with self-closing cover devices. This deficient practice could affect up to 20 residents in the court yard and staff outside the service exit. Findings include: Based on observation during a tour of the facility with Maintenance Director on 12/09/16 between 8:55 a.m. and 11:10 a.m., the flowing was observed: a) In the staff smoking area outside by the service hall exit there were over 50 cigarette butts on the ground from the service hall exit into the smoking area. b) In the courtyard were the resident	K 0741	**K741** A different storage area for the gas grill has been determined on 12/12/16. All staff will be in-serviced on facility Employee Smoking Policy, in mandatory all-staff in-service on 01/03016. Each resident who smokes will be counselled by SSD, on the facility's Resident Smoking Policy by 01/08/17. The policy will also be reviewed with the facility's Resident Council in their Jan. 2017 meeting. Inspection of both smoking areas will be added to the Maint. Dir. Monthly PM schedule. Maint. Dir. will report compliance to the QA Committee Quarterly.	01/08/2017

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	smoking area is locate there were over 20 cigarette butts on patio, grass, and mulch around the smoking area. Based on interview at the time of observation, the Maintenance Director acknowledged the cigarette butts on the ground in both smoking areas. 3.1-19(b) 2. Based on observation and interview; the facility failed to ensure 1 of 2 smoking areas did not contain flammable liquids or combustible gases. This deficient practice could affect all staff outside the service hall exit. Findings include: Based on observation during a tour of the facility with Maintenance Director on 12/09/16 at 11:11 a.m., next to the staff smoking area outside the service hall exit there was a gas grill with a propane tank. Smoking by the propane tank was apparent due to cigarette butts on the ground within 12 inches of the gas grill. Based on interview at the time of observation, the Maintenance Director acknowledged smoking took place next to a propane tank. 3.1-19(b)			

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K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failed ensure 1 of 1 space heaters were not used in a resident care area. This deficient practice could affect 15 residents in the central lounge. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 12/09/16 at 12:15 p.m., an electric fire place equipped with a space heater was located in the central lounge. Based on interview at the time of observation, the Maintenance Director acknowledged that the fire place produces heat. 3.1-19(b)	K 0781	**K781** The heating element of the electric fireplace in the main lounge, has been permanently disconnected/disabled on 12/16/16. Facility inspection for space heaters is a part of Maint. Dir. Monthly PM schedule. Maint. Dir. will report compliance to the QA Committee quarterly.	01/08/2017
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the			

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	10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby	K 0918	**K918** The reprograming of the emergency generator software to separate the generator's cool down time separately from its run time was completed on 12/20/16. Maintenance logs have been adjusted to record both run time and cool down time separately.	01/08/2017

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	Powers Systems, Chapter 8. NFPA 110, 6.4.2.1.5.9 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 shutdown. 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 record review with the Maintenance Director on 12/08/16 at 10:37 a.m., the generator log form documented the generator was tested monthly for at least 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. Based on interview at the time of record review, the Maintenance Director stated the generator run program does not include a cool down time. 3.1-19(b)			