STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155210	A. BUILDING 01 B. WING	06/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

(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: 06/20/17 Facility Number: 000117 Provider Number: 155210 AIM Number: 100266460 At this Life Safety Code survey, Heritage House of Greensburg 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 (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 57 at the time of this visit.	K 0000	K 0000 Please accept this Plan of Correction as our credible allegation of compliance for the deficiencies noted in the 2567 for the Heritage House of Greensburg. We are alleging compliance by July 20, 2017 and request a paper compliance review if applicable.	

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

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	All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review by Lex Brashear, Life Safety Code Specialist on 06/22/17.			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. 18.2.7, 19.2.7, S&C 05-38 Based on observation and interview, the facility failed to ensure 1 of 11 exit discharges was constructed to prevent elevation changes in accordance with LSC 7.1.7. LSC 7.1.6.2 requires abrupt changes in elevation of walking surfaces shall not exceed 1/4 in. (6.3 mm). Changes in elevation exceeding 1/4 in. (6.3 mm), but not exceeding 1/2 in. (13 mm), shell be beveled with a slope of 1 in 2. Changes in elevation exceeding 1/2 in. (13 mm) shall be considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice affects 10 residents who reside on the Station 3 North Hall.	K 0271	K 0271 It is the intent of this facility to provide safe level walking surfaces for all exit discharges with respect to changes in elevation and to be maintained free of obstructions. None of the 10 residents identified who reside on the north hall were affected by this deficient practice. The 2 north hall exit sidewalk surfaces outside the exit doors directly east and west where the cement slabs come together have been repaired. This reconstruction corrects the differences in elevations to both sidewalk surfaces to eliminate abrupt changes to these	07/20/2017

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	Findings include: Based on observation with the maintenance supervisor on 06/20/17 at 4:00 p.m., the Station 3 North Hall exit sidewalk surface had a one half inch elevation difference on the four foot by eight foot concrete slab directly west outside the exit door along the edge where the two concrete slabs came together, and a one half inch elevation difference in the four foot by eight foot concrete slab directly east outside the exit door where the two concrete slabs came together. This was measured and verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/20/17 at 4:30 p.m. 3.1-19(b)		surfaces. The other 9 exit discharges were also checked to ensure there were no abrupt changes in elevation to these surfaces and any necessary changes were made. The maintenance director will monitor monthly during routine exterior rounds of the facility. Any future findings will be brought to the attention of the administrator so necessary repairs can be made to assure all sidewalks are of safe level surfaces.	
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			

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	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 4 of 14 hazardous areas, such as combustible storage rooms over 50 square feet and soiled linen rooms, were either provided with self-closing devices which would cause the doors to automatically close and latch into the door frames or the doors were smoke resistant. This deficient practice affects 14 residents who reside on the Long Hall and any residents who use the main dining room located in the Long Hall, and 24 residents who reside on the Special Care Unit Hall.	K 0321	K 0321 This deficient practice cited did not directly affect the 14 residents who reside on the long hall or who use the main dining room nor the 24 residents who reside on the special care unit. It is the intent of this facility for all of our doors to resist the passage of smoke. The doors and door frames identified were: a. long hall soiled utility room door b. long hall storage room door and c. special care unit hall storage room doors. All were found to have circular holes near the top and have been filled with wood putty and fire caulk. All other doors and door frames through out the facility found to	07/20/2017

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	Findings include: Based on observations on 06/20/17 during a tour of the facility with the maintenance supervisor from 11:55 a.m. to 4:30 p.m., the following hazardous areas had either doors that failed to resist the passage of smoke or failed to latch and self close into the door frame; a. The Long Hall soiled linen room door had a one half inch diameter circular hole in the door frame near the top of the latching side of the door, preventing the door from resisting the passage of smoke. b. The Long Hall storage room, which measured one hundred twenty square feet and stored combustible paper and plastic supplies, had four, one eighth inch diameter circular holes on both sides of the door frame near the top of each side of the door frame, preventing the door from resisting the passage of smoke. c. The Special Care Unit Hall storage room, which measured one hundred eighty square feet and stored combustible paper and plastic supplies, had two one quarter inch diameter circular holes in the door near the top hinge side of the door, preventing the door from resisting the passage of smoke. d. The Special Care Unit Hall linen storage room, which measured one hundred twenty square feet and stored eight shelves of combustible clean linen,		have small circular holes have also been filled with wood putty and fire caulk. Repairs, adjustments, and changes were made to the door and door knob of the special care unit storage room so it will close properly into the door frame without any gaps. The maintenance director will monitor during daily rounds to observe for any other doors which may need adjustments or holes filled so all doors continue to be smoke resistive.	

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	had a door that failed to self close into the door frame on two separate attempts and had a one inch gap along the latching side of the door. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/20/17 at 4:30 p.m. 3.1-19(b)			
K 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for 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, observation and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was	K 0324	K 0324 It is the policy of this facility to protect residents, employees, and visitors at all times. Their safety	07/20/2017

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	inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect seven staff and visitors in the kitchen. Findings include: Based on review of the Allied Safety Fire Protection records on 06/20/17 at 11:55 a.m. with the administrator, the most current semi-annual inspection record available for review to indicate a semi-annual kitchen fire suppression system inspection was conducted was dated 06/14/16 and the previous semi-annual inspection conducted by Allied Safety Fire Protection was dated 06/15/15. The lack of a a semi-annual kitchen fire suppression system inspections was verified by the administrator at the time of record review and acknowledged by the administrator at		includes the required inspections of kitchen equipment. None were affected by this finding. The more recent semi-annual kitchen fire suppression system inspections dated 12/07 & 6/14 2016 and 12/10 & 6/5 2015 conducted timely by Allied Safety Services are all on file now (please see attachments 1 thru 4). The current inspection date completed 6/22/17 by Allied Safety Services is also on file (please see attachment 5). The administrator or designee is responsible to review all inspections monthly and will continue to monitor ongoing so the fire suppression system inspections are completed timely and filed as required.	

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	the exit conference on 06/20/17 at 4:30 p.m. 3.1-19(b)			
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation and interview, the facility failed to ensure 2 of 60 Station 3 Hall rooms were provided with an interior finish with a flame spread rating of Class A or Class B. LSC 3.3.90.2 identifies interior finish as the exposed surfaces of walls, ceilings, and floors within building. A.3.3.90.2 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient practice could affect 10 residents who reside on the Station 3 Hall. Findings include: Based on observations on 06/20/17	K 0331	K 0331 None of the 10 residents identified were directly affected by this deficient practice. The missing drywall on the north wall of the sprinkler riser room has since been reinstalled to cover the exposed wooden studs. The drywall has also been replaced on the east wall in the computer equipment room to cover the opening in the surface of this wall. The installation with spackling around the drywall seals both of these areas and provides an interior finish. Maintenance Director will observe ongoing during daily rounds. Any other walls found with exposed surfaces will be repaired as needed.	07/20/2017

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	during a tour of the Station 3 Hall from 3:00 p.m. to 3:45 p.m. with the maintenance supervisor, the Station 3 sprinkler riser room north wall had a three foot by four foot square area of drywall missing with bare wooden studs exposed, and the Station 3 Hall computer room east wall had a four inch by six inch area of drywall missing in the center of the wall. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/20/17 at 4:30 p.m. 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			

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	Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1 states all valves shall be inspected weekly. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the Station 3 Hall sprinkler riser room Weekly Pressure Gauge Inspection Form and the Station 4 Hall sprinkler riser room Weekly Pressure Gauge Inspection Form with the maintenance supervisor during record review from 11:55 a.m. to 1:00 p.m. on	K 0353	K 0353 All occupants have the potential to be affected by this deficient practice. However, no residents, staff, nor visitors were affected. A column as been added to the Weekly Pressure Gauge Inspection Form (see attachment 6) to include weekly inspections now of the control valves in the sprinkler riser rooms on both area 3 and station 4 halls. The addition of this inspection will maintain records that are readily available to ensure the control valves are in good condition. The maintenance director will inspect equipment and record weekly so documentation is completed timely as required.	07/20/2017

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	06/20/17, the Weekly Pressure Gauge Inspection Forms located in the Station 4 Hall and Station 3 Hall sprinkler riser rooms listed each sprinkler water and air gauge pressure readings each week over the past six months but lacked the control valve inspection for the one control valve in each of the two sprinkler system riser rooms located on the Station 3 and Station 4 Halls. The lack of the two control valves inspected monthly was verified by the maintenance supervisor at the time of record review acknowledged by the administrator at the exit conference on 06/20/17 at 4:30 p.m. 3.1-19(b)			
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			

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	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 facility failed to ensure 1 of 38 Special Care Unit Hall room corridor doors and 1 of 32 Long Hall corridor doors would resist the passage of smoke. This deficient practice affects 24 residents who reside on the Special Care Unit Hall and 14 residents who reside on the Long Hall including any number of residents who use the Long Hall main dining room. Findings include: Based on observation on 06/20/17 during a tour of the facility from 11:55 a.m. to 4:30 p.m. with the maintenance supervisor, the Special Care Unit Hall	K 0363	K 0363 No residents have been directly affected by this deficient practice which could affect 24 residents who reside in the special care unit and 14 residents who reside on the long hall including all residents who use the long hall to the main dining room. Necessary adjustments have been made to the doors identified as corridor hall door of the special care unit and a corridor door in the long hall to ensure both doors will resist the passage of smoke. Both the janitor room door to the special care unit and the long hall folding room door found with small holes near the top have been filled with wood putty to prevent the door from resisting	07/20/2017

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	janitor room door had two, one half inch diameter circular holes in the door near the top latching side of the door, which prevented the door from resisting the passage of smoke and the Long Hall folding room door had two, one half inch diameter circular holes in the door near the top latching side of the door, which prevented the door from resisting the passage of smoke. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/20/17 at 4:30 p.m. 3.1-19(b)		the passage of smoke. All other corridor doors and interior doors within the entire facility have been checked and will continue to be monitored by the maintenance director during daily rounds. Any doors found with holes will be filled with wood putty and fire caulk.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or	K 0372	K 0372 None of the 14 residents who reside on the long hall nor other	07/20/2017

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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
	conduit through 2 of 8 attic 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 14 residents who reside on the Long Hall and any residents who use the main dining room located in the Long Hall. Findings include: Based on observations with the maintenance supervisor on 06/20/17 during a tour of the attic smoke barrier walls from 2:30 p.m. to 3:00 p.m. on 06/20/17, the Long Hall center attic smoke barrier wall had a four inch by two inch opening at the top of the smoke barrier wall where the roof peak met not fire stopped on both sides of the smoke barrier wall, and the Long Hall end hall attic smoke barrier wall had a two inch open with electrical conduit not fire stopped on both sides of the smoke barrier wall. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/20/17 at 4:30 p.m. 3.1-19(b)		residents who use the long hall to reach the main dining room have been affected by this deficient practice. The long hall center attic smoke barrier wall where the roof peaks has been dry walled and fire caulked on both sides of the wall. The end of the long hall attic smoke barrier wall with a 2 inch gap caused from the passage of electrical conduit was fire caulked on both sides of the smoke barrier wall. Sealing the openings in these 2 smoke barrier walls protect and maintain the smoke resistance of each smoke barrier walls. The other 6 smoke barrier walls were also checked for any gaps or openings. The maintenance director will continue to monitor all smoke barrier walls monthly to ensure walls remain smoke resistant.	

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	155210	A. BUILDING 01 B. WING	06/20/2017

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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 and interview, the facility failed to ensure 2 of 9 occupied space smoke barrier doors and 1 of 9 attic smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 14 residents who reside on the Long Hall and any residents who use the Long Hall main dining room, 37 residents who reside on the Station 1 Hall, and 24 residents who	K 0374	K0374 This deficient practice affects all residents within the facility on both stations. However, no residents have been directly affected from this finding. The first hall corridor smoke barrier door with holes at the top on the south door were filled with wood putty and fire caulk. Adaptions were made to the special care unit corridor smoke barrier doors along the edge where the doors come together in the closed position. Necessary repairs were made to the end of the long hall attic smoke barrier door to seal the one inch gap in the closed position along the non hinged side of the door. These changes allow for minimum clearance necessary so these smoke barrier doors close	07/20/2017

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	reside on the Special Unit Hall. Findings include: Based on observations on 06/20/17 during a tour of the facility from 11:55 a.m. to 4:30 p.m. with the maintenance supervisor, the Station 1 Hall corridor smoke barrier door had two, one half inch circular holes at the top of the south door, the Special Care Unit Hall corridor smoke barrier doors had a one half inch gap along the edge where the doors came together in the closed position, and the Long Hall end hall attic smoke barrier door had a one inch gap along the non-hinge side of the door in the closed position. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/20/17 at 4:30 p.m. 3.1-19(b)		and seal properly to restrict the movement of smoke. All other smoke barrier doors and attic smoke barrier doors were also checked and will continue to be monitored monthly for proper operation by the maintenance director.	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air	K 0521	K 0521 Smoke and duct detectors were installed which upon activation of	07/20/2017

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	system serving adjoining rooms for 84 of 84 resident rooms and 8 of 8 egress corridors. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, Section 4.3.12.1.1 states egress corridors in nursing and long term care facilities shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on observations with the maintenance supervisor during a tour of the facility on 06/20/17 from 11:55 a.m. to 4:30 p.m., all eighty four resident rooms and eight corridors were using the egress corridor as a return air system. Based on interview at the time of the observations, the maintenance supervisor verified the eighty four resident rooms were using the egress corridor as a return air system. This was acknowledged by the administrator at the exit conference on 06/20/17 at 4:30 p.m.		the fire alarm system will shut down all of the air handling units. Smoke dampers have also been installed in the ducts which will close upon activation of the fire alarm system thus preventing the transfer of smoke from one smoke/fire zone to another. The units under 2000 CFM capacity have been tied to the central fire alarm system panel enabling the units to shut down upon the activation of the fire alarm system. Therefore, we are requesting that a waiver be granted with regard to this finding. Please see Life Safety Code Waiver Request Form and Attachment A.	

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	3.1-19(b)			
K 0711 SS=F 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, observation 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 (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation	K 0711	K 0711 The facility has a written disaster plan in place for the protection of all residents and for evacuation in the event of a fire or similar emergency to maintain a clear evacuation path. All occupants could be affected if this practice is not followed. All staff were aware and already trained on the proper procedure to relocate wheeled equipment to the central bathrooms or storage areas. Doing so allows for a clear means of egress in the event there is a need to evacuate. The evacuation route of the written safety plan has since been reviewed and is updated now to include the relocation of wheeled equipment in the corridors during an emergency evacuation (please	07/20/2017

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	(9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants. Findings include: Based on review of written Disaster Plan and Fire Policy with the administrator on 06/20/17 at 12:15 p.m., the written Disaster Plan and Fire Policy did not address the relocation of wheeled equipment and patient lifts during a fire or similar emergency. Based on interview at the time of review, the administrator acknowledged the aforementioned written fire safety plan did not address the relocation of wheeled equipment and patient lifts during a fire		see attachment 7). Staff will continue to be reminded during monthly fire drills or other similar emergency drills for a clear evacuation route. New staff will also be instructed on this procedure. The charge nurse conducting the drill will monitor that staff are kept informed to address the need for relocation of any wheeled equipment. Administrator or designee is responsible to review that this practice occurs during drills or in the event of an emergency.	

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	or similar emergency. This was acknowledged by the administrator at the exit conference on 06/20/17 at 4:30 p.m. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, it could not be assured 2 of 84 resident rooms power strips used in patient care vicinities met UL 1363A or UL60601-1. NFPA 99, Standard for Health Care	K 0920	K 920 No residents have been affected by this deficient practice which could affect up to 4 residents who may reside in resident rooms 70 and 88.	07/20/2017

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	Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. This deficient practice could affect 4 residents who reside in resident room 70 and resident room 88. Findings include: Based on observations with the maintenance supervisor during a tour of the facility on 06/20/17 from 11:55 a.m. to 4:30 p.m., resident room 70 and resident room 88 each had a power strip in use without a UL 1363A or UL60601-1 listing on each power strip used to power bed side lights, clock radios, computers, fans, televisions, and telephone charger. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/20/17 at 4:30 p.m.		It is the intent of this facility to use general precautions with power strips at all times. The particular types of power strips allowed will be included in our written safety plan. The 2 power strips found in room 70 and 88 without proper UL listings on each strip are being replaced with new power strips that meet the UL 60601-1 standard for patient care vicinities. Staff are being instructed to observe ongoing in all resident rooms for inappropriate power strips in use so any discovered can be replaced with acceptable strips that meet the required standard. Any power strips used outside the patient care vicinity will also meet the required UL standard. The maintenance director is responsible when informed to advise the administrator or designee of the need to replace a power strip.	

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