STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	10/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTENHEIM HEALTH & LIVING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237

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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: 10/07/16 Facility Number: 000103 Provider Number: 155196 AIM Number: 100290000 At this Life Safety Code survey, Altenheim Health and Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility, occupying the A, B and C wings of the first floor of a three story building with a basement, was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the	K 0000	This plan of correction is to serve Altenheim Family First Senior Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Altenheim Family First Senior Living or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We would like to respectfully request paper compliance for Altenheim Family First Senior Living's Life Safety Code Survey.	

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

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	corridor. The facility has smoke detectors hard wired to the building electrical system in the A, B and C wings. The facility has a capacity of 87 and had a census of 75 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 10/13/16 - DA			
K 0046 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD 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 record review, observation and interview; the facility failed to document monthly functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights for 1 of 12 months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all	K 0046	**K046 – Emergency Light Documentation** **1. What corrective Actions will be accomplished for those residents found to have been affected by the deficient practice?** *The check off sheet has been modified to show that the functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights is conducted monthly. 2. **How will other residents having the potential to be affected by the**	10/27/2016

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	residents, staff and visitors. Findings include: Based on review of "Direct Supply TELS: Emergency Power Generators Test Generator Under Load", "EPSS Weekly Test Log" and "Battery Backup Emergency Light Testing for 2016" documentation with the Director of Maintenance and the Regional Facilities Manager during record review from 8:45 a.m. to 11:50 a.m. on 10/07/16, documentation of monthly functional testing for not less than 30 seconds for three battery powered emergency lights located at the emergency generator for September 2016 was not available for review. Based on interview at the time of record review, the Director of Maintenance stated there are three battery operated emergency lights located at the emergency generator inside the facility and acknowledged documentation of monthly functional testing for not less than 30 seconds for the three battery powered emergency lights located at the emergency generator for September 2016 was not available for review. Based on observations with the Director of Maintenance and the Regional Facilities Manager during a tour of the facility from 12:40 p.m. to 3:05 p.m. on 10/07/16, each of the three battery powered		**same deficient practice by identified and what corrective action will be taken?** *All residents, staff, and visitors in the Rehabilitation Facility have the potential to be affected by the alleged deficient practice. *Maintenance Director/Designee will audit and document monthly functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights. **3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur?** *Administrator/Designee will review documentation monthly to ensure that the functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights is conducted monthly. *Maintenance Director/Designee Director will be educated by October 27 2016 by Administrator/Designee on ensuring that the functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights is conducted monthly. **4. How will the corrective actions be monitored to ensure the deficient practice will not recur,**	

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	emergency lights at the emergency generator location inside the facility illuminated when its respective test button was pushed. 3.1-19(b)		**and what quality assurance program.** *Emergency Lighting CQI will be completed weekly X 4, monthly x 2, the quarterly thereafter until compliance is 100% to ensure that the functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights is conducted monthly by the Maintenance Director/Designee. *The results of these audits will be reviewed by the Quality Assurance Committee weekly until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	
K 0050 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 Based on record review and interview, the facility failed to document fire drills	K 0050	**1. What corrective Actions will be accomplished for those residents found to have been affected by the**	10/27/2016

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	conducted on the first shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Direct Supply: TELS - Fire Drills" and "Fire Drill Report" documentation with the Director of Maintenance and the Regional Facilities Manager during record review from 8:45 a.m. to 11:50 a.m. on 10/07/16, documentation of a fire drill conducted on the first shift in the fourth quarter (October, November, December) 2015 was not available for review. Based on interview at the time of record review, the Regional Facilities Manager stated additional fire drill documentation not was available for review and acknowledged documentation of a fire drill conducted on the first shift in the fourth quarter 2015 was not available for review. 3.1-19(b) 3.1-51(c)		**deficient practice?** *Fire drills have been completed and documented for all 1st, 2nd, and 3rd quarters on each shift in 2016. 2. **How will other residents having the potential to be affected by the same deficient practice by identified and what corrective action will be taken?** *All residents, staff, and visitors in the Rehabilitation Facility have the potential to be affected by the alleged deficient practice. *The Maintenance Director will follow a schedule on a 12 month calendar to ensure fire drills are completed quarterly on all shifts. **3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur?** *The Maintenance Director will use a schedule on a 12 month calendar to follow to ensure fire drills are completed quarterly on all shifts. *Maintenance Director/Designee Director will be educated by October 27, 2016 by Administrator/Designee on ensuring fire drills are completed quarterly on all shifts. *Administrator/Designee will audit fire drills monthly to ensure they are	

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			being conducted quarterly on all shifts. **4. How will the corrective actions be monitored to ensure the deficient practice will not recur, and what quality assurance program.** *A Fire Drill CQI will be completed monthly x4, quarterly x2, and monthly thereafter until compliance reached 100% to ensure they are being conducted quarterly on all shifts by the Maintenance Director/Designee. *The results of these audits will be reviewed quarterly by the Quality Assurance Committee until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	
K 0062 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. LSC 9.7.1 states all automatic	K 0062	**1. What corrective Actions will be accomplished for those residents found to have been affected by the deficient practice?** *Data Cable has been removed from the support bracket near the ceiling	10/27/2016

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	sprinkler systems shall be maintained in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 states sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Storage Room outside the kitchen near the loading dock. Findings include: Based on observation with the Director of Maintenance and the Regional Facilities Manager during a tour of the facility from 12:40 p.m. to 3:05 p.m. on 10/07/16, a ten foot length of data cable was run through one support bracket for a four inch in diameter horizontal sprinkler pipe near the ceiling in the Storage Room outside the kitchen near the loading dock. Based on interview at the time of observation, the Director of Maintenance and the Regional Facilities Manager acknowledged the aforementioned sprinkler pipe location was being used to support nonsystem components. 3.1-19(b)		in the Storage Room outside the kitchen near the loading dock. 2. **How will other residents having the potential to be affected by the same deficient practice by identified and what corrective action will be taken?** *All residents, staff, and visitors in the vicinity of the Storage Room outside of the Kitchen have the potential to be affected by the alleged deficient practice. *Maintenance Director/Designee has audited automatic sprinkler systems to ensure the sprinkler pipe locations are not used to support non system components. **3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur?** *The Maintenance Director/Designee will check sprinkler systems weekly to ensure the sprinkler pipe locations are not being used to support non system components. *Maintenance Director/Designee Director will be educated by October 27, 2016 by Administrator/Designee on ensuring sprinkler pipe locations are not used to support non system components.	

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			4. How will the corrective actions be monitored to ensure the deficient practice will not recur, and what quality assurance program. *Sprinkler System CQI will be completed will be completed weekly x4, monthly x2, and quarterly thereafter until compliance reached 100% to ensure sprinkler pipe locations are not used to support non system components. *The results of these audits will be reviewed quarterly by the Quality Assurance Committee until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	
K 0064 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 Based on observation and interview, the facility failed to document inspection of 1 of 4 portable fire extinguishers in the kitchen each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In	K 0064	**1. What corrective actions will be accomplished for those resident found to have been affected by the deficient practice?** *The portable ABC type fire extinguisher in the Therapy Room in the Rehabilitation Wing has had its monthly inspection for October.	10/27/2016

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	addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect 5 staff and visitors in the kitchen. Findings include: Based on observation with the Director of Maintenance and the Regional Facilities Manager during a tour of the facility from 12:40 p.m. to 3:05 p.m. on 10/07/16, the portable ABC type fire extinguisher near the east exit door from the kitchen had an inspection tag affixed to the extinguisher which indicated an annual inspection was conducted in January 2016. However, a monthly inspection was not documented for July, August and September 2016. Based on interview at the time of observation, the Director of Maintenance stated no other monthly fire extinguisher inspection documentation was available for review and acknowledged a monthly inspection for the aforementioned portable fire extinguisher in the kitchen was not documented for July, August and		**2. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *Residents, staff, and visitors in the Therapy Room in the Rehabilitation Wing have the potential to be affected by the alleged deficient practice. *All ABC type fire extinguishers have been audited by Maintenance Director/Designee to ensure they have had their monthly inspections completed. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *Maintenance Director/Designee will audit all ABC type fire extinguishers to ensure they are inspected monthly. *Maintenance Director/Designee Director will be educated by October 27, 2016 by Administrator/Designee on ensuring all ABC type fire extinguishers are inspected monthly. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?**	

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	September 2016. 3.1-19(b)		*Fire Extinguisher CQI will be completed monthly x 4, and quarterly thereafter until compliance is at 100% by Maintenance Director/Designee. *The results of these audits will be reviewed by the Quality Assurance Committee monthly times 4, and quarterly thereafter until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	
K 0143 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8-6.2.5.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 2 liquid oxygen storage areas where transferring	K 0143	**1. What corrective Actions will be accomplished for those residents found to have been affected by the**	10/27/2016

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	of oxygen takes place was in an area posted with signs indicating transferring of oxygen is occurring. This deficient practice could affect 15 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room near the Memory Care Dining Room. Findings include: Based on observation with the Director of Maintenance and the Regional Facilities Manager during a tour of the facility from 12:40 p.m. to 3:05 p.m. on 10/07/16, the oxygen storage and transfilling room near the Memory Care Dining Room had six liquid oxygen containers stored in the room and the area was not posted with signs indicating the transferring of oxygen occurs in the room. Based on interview at the time of observation, the Director of Maintenance and the Regional Facilities Manager stated they were unaware if the room was used as an oxygen transfilling room but acknowledged the room was not posted with signs indicating the transferring of oxygen occurs in the room. Based on exit interview at 3:25 p.m., the Administrator acknowledged transferring of oxygen takes place in each of the two oxygen and storage and transfilling rooms in the facility.		**deficient practice?** *A temporary sign has been placed on the oxygen storage room door located on the locked unit indicating that the transferring of oxygen occurs in the room. *A permanent sign has been ordered through assigned vendor. 2. **How will other residents having the potential to be affected by the same deficient practice by identified and what corrective action will be taken?** *Residents, staff, and visitors on the locked unit have the potential to be affected by the alleged deficient practice. *Maintenance Director/Designee have audited 2 of 2 oxygen transfillling room doors to ensure signs are present indicating that the transferring of oxygen occurs in the room. **3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur?**	

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	3.1-19(b)		*Maintenance Director/Designee will audit the oxygen transfilling room doors to ensure a sign is present indicating that the transferring of oxygen occurs in the room. *Maintenance Director/Designee Director will be educated by October 27, 2016 by Administrator/Designee on ensuring that transfilling room doors have a sign present indicating that the transferring of oxygen occurs in the room. **4. How will the corrective actions be monitored to ensure the deficient practice will not recur, and what quality assurance program.** *O2 Room CQI will be completed by Maintenance Director/Designee weekly x 4, monthly times 2, and quarterly thereafter until compliance is at 100% *The results of these audits will be reviewed by the Quality Assurance Committee weekly x 4, monthly times 2, and quarterly thereafter until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	

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K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.6 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 1999 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 feet (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 feet 6 inches. (2.3 m) above the floor. NFPA 99, Section 7-5.2.2.1 states household or office	K 0147	**1. What corrective Actions will be accomplished for those residents found to have been affected by the deficient practice?** *The power wheelchair and oxygen concentrator are no longer plugged into a power strip in room 1086. 2. **How will other residents having the potential to be affected by the same deficient practice by identified and what corrective action will be taken?** *Residents, staff, and visitors within the vicinity of room 1086 have the potential to be affected by the alleged deficient practice. *Maintenance Director/Designee will audit rooms in the facility to ensure power strips are not being used as a substitute in place of fixing wiring and power strips are not being used in patient care vicinity by October 27, 2016.	10/27/2016

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	appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 15 residents, staff and visitors in the vicinity of Room 1086. Findings include: Based on observation with the Director of Maintenance and the Regional Facilities Manager during a tour of the facility from 12:40 p.m. to 3:05 p.m. on 10/07/16, a motorized wheelchair was plugged into a power strip in Room 1086. In addition, an oxygen concentrator was plugged into a power strip on the floor one foot from the resident bed in Room 1086. Based on interview at the time of the observations, the Director of Maintenance and the Regional Facilities Manager acknowledged power strips were being used as a substitute for fixed wiring in Room 1086 and one of the power strips was also being used in the patient care vicinity in Room 1086. 3.1-19(b)		**3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur?** *Caring Hearts Representatives will audit rooms weekly to ensure power strips are not being used as a substitute in place of fixing wiring and power strips are not being used in patient care vicinity. *Administrator/Designee will educate Maintenance Director and Maintenance Assistant by October 27, 2016 on ensuring power strips are not being used as a substitute in place of fixing wiring and power strips are not being used in patient care vicinity. *Maintenance Director will education staff, including, Caring Hearts Reps by October 27, 2016 on ensuring power strips are not being used as a substitute in place of fixing wiring and power strips are not being used in patient care vicinity. **4. How will the corrective actions be monitored to ensure the deficient practice will not recur, and what quality assurance program.**	

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			*Maintenance Director/Designee will complete the Patient Room Electrical Wiring CQI weekly x 4, monthly times 2, and quarterly thereafter until compliance is at 100% *The results of these audits will be reviewed by the Quality Assurance Committee weekly x 4, monthly times 2, and quarterly thereafter until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	
K 0000 Bldg. 02	A Life Safety Code Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/07/16 Facility Number: 000103 Provider Number: 155196 AIM Number: 100290000 At this Life Safety Code Survey, Altenheim Health and Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart	K 0000	This plan of correction is to serve Altenheim Family First Senior Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Altenheim Family First Senior Living or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We would like to respectfully request paper compliance for Altenheim Family First Senior Living's Life Safety Code Survey.	

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	483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. The one story Rehabilitation Wing constructed in 2014 was determined to be of Type V (111) construction and was fully sprinklered. The Rehabilitation Wing has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and has smoke detectors hard wired to the fire alarm system in resident sleeping rooms. The facility has a capacity of 87 and had a census of 75 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 10/13/16 - DA			
K 0038 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 7 exits were readily	K 0038	**What corrective actions will be accomplished for those resident found to have been affected by the deficient practice?**	10/27/2016

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	accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 18.2.2.2.4 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. Exception No. 1 states door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 20 residents, staff and visitors if needing to exit the facility at the main entrance for the Rehabilitation Wing. Findings include: Based on observation with the Director of Maintenance and the Regional Facilities Manager during a tour of the facility from 12:40 p.m. to 3:05 p.m. on 10/07/16, the main entrance door for the Rehabilitation Wing was marked as a facility exit and was magnetically locked and could be opened at night by entering a four digit code but the code was not posted. At the time of the survey, the door was unlocked and residents, staff and visitors could exit the facility without entering the four digit		*The 4 digit exit code is now posted at the main entrance for the Rehabilitation Wing. **How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *Residents, staff, and visitors needing to exit the facility at the main entrance on the Rehabilitation Wing have the potential to be affected by the alleged deficient practice. *Maintenance Director/Designee will audit all exit doors on units housing residents that are not on a locked unit to ensure an exit code is posted by October 27, 2016. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *Maintenance Director will audit all exit doors on units housing residents that are not on a locked unit to ensure an exit code is posted weekly. *Administrator/Designee will educate Maintenance Director/Designee to ensure all exit doors on units housing residents that are not on a locked units have	

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	code to release the door. Based on interview at the time of observation, the Director of Maintenance and the Regional Facilities Manager stated the main entrance door for the Rehabilitation Wing is unlocked during the day, the door is locked at night, residents with a diagnosis requiring specialized security measures reside in the Memory Care portion of the facility and acknowledged the four digit code was not posted at the aforementioned entrance to enable residents, staff and visitors to exit the facility from the Rehabilitation Wing main entrance smoke compartment in the event of an evacuation at night. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code. 3.1-19(b)		an exit code is posted by October 27, 2016. **How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** *Maintenance Director/Designee will complete the Exit Door CQI weekly x 4, monthly times 2, and quarterly thereafter until compliance is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%. *The results of these audits will be reviewed by the Quality Assurance Committee weekly x 4, monthly times 2, and quarterly thereafter until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	
K 0046 SS=C Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD 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 record review, observation and interview; the facility failed to document monthly functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights for 1 of 12	K 0046	**K046 – Emergency Light Documentation** **1. What corrective Actions will be accomplished for those residents found to have been affected by the**	10/27/2016

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	months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Direct Supply TELS: Emergency Power Generators Test Generator Under Load", "EPSS Weekly Test Log" and "Battery Backup Emergency Light Testing for 2016" documentation with the Director of Maintenance and the Regional Facilities Manager during record review from 8:45 a.m. to 11:50 a.m. on 10/07/16, documentation of monthly functional testing for not less than 30 seconds for three battery powered emergency lights located at the emergency generator for September 2016 was not available for review. Based on interview at the time of record review, the Director of Maintenance stated there are three battery operated emergency lights located at the emergency generator inside the facility and acknowledged documentation of		**deficient practice?** *The check off sheet has been modified to show that the functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights is conducted monthly. 2. **How will other residents having the potential to be affected by the same deficient practice by identified and what corrective action will be taken?** *All residents, staff, and visitors in the Rehabilitation Facility have the potential to be affected by the alleged deficient practice. *Maintenance Director/Designee will audit and document monthly functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights. **3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur?** *Administrator/Designee will review documentation monthly to ensure that the functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights is conducted monthly. *Maintenance Director/Designee	

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	monthly functional testing for not less than 30 seconds for the three battery powered emergency lights located at the emergency generator for September 2016 was not available for review. Based on observations with the Director of Maintenance and the Regional Facilities Manager during a tour of the facility from 12:40 p.m. to 3:05 p.m. on 10/07/16, each of the three battery powered emergency lights at the emergency generator location inside the facility illuminated when its respective test button was pushed. 3.1-19(b)		Director will be educated by October 27 2016 by Administrator/Designee on ensuring that the functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights is conducted monthly. **4. How will the corrective actions be monitored to ensure the deficient practice will not recur, and what quality assurance program.** *Emergency Lighting CQI will be completed weekly X 4, monthly x 2, the quarterly thereafter until compliance is 100% to ensure that the functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights is conducted monthly by the Maintenance Director/Designee. *The results of these audits will be reviewed by the Quality Assurance Committee weekly until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	
K 0050 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is			

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	familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 Based on record review and interview, the facility failed to document fire drills conducted on the first shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Direct Supply: TELS - Fire Drills" and "Fire Drill Report" documentation with the Director of Maintenance and the Regional Facilities Manager during record review from 8:45 a.m. to 11:50 a.m. on 10/07/16, documentation of a fire drill conducted on the first shift in the fourth quarter (October, November, December) 2015 was not available for review. Based on interview at the time of record review, the Regional Facilities Manager stated additional fire drill documentation not was available for review and acknowledged documentation of a fire drill conducted on the first shift in the fourth quarter 2015 was not available for review.	K 0050	**1. What corrective Actions will be accomplished for those residents found to have been affected by the deficient practice?** *Fire drills have been completed and documented for all 1st, 2nd, and 3rd quarters on each shift in 2016. 2. **How will other residents having the potential to be affected by the same deficient practice by identified and what corrective action will be taken?** *All residents, staff, and visitors in the Rehabilitation Facility have the potential to be affected by the alleged deficient practice. *The Maintenance Director will follow a schedule on a 12 month calendar to ensure fire drills are completed quarterly on all shifts. **3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur?** *The Maintenance Director will use a schedule on a 12 month calendar	10/27/2016

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	3.1-19(b) 3.1-51(c)		to follow to ensure fire drills are completed quarterly on all shifts. *Maintenance Director/Designee Director will be educated by October 27, 2016 by Administrator/Designee on ensuring fire drills are completed quarterly on all shifts. *Administrator/Designee will audit fire drills monthly to ensure they are being conducted quarterly on all shifts. **4. How will the corrective actions be monitored to ensure the deficient practice will not recur, and what quality assurance program.** *A Fire Drill CQI will be completed monthly x4, quarterly x2, and monthly thereafter until compliance reached 100% to ensure they are being conducted quarterly on all shifts by the Maintenance Director/Designee. *The results of these audits will be reviewed quarterly by the Quality Assurance Committee until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	
K 0064 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed,			

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	inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 Based on observation and interview, the facility failed to document inspection of 1 of 1 portable fire extinguishers in the Therapy Room of the Rehabilitation Wing each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect 5 residents, staff and visitors in the Therapy Room of the Rehabilitation Wing. Findings include: Based on observation with the Director of Maintenance and the Regional Facilities Manager during a tour of the facility from 12:40 p.m. to 3:05 p.m. on 10/07/16, the portable ABC type fire extinguisher in	K 0064	**1. What corrective actions will be accomplished for those resident found to have been affected by the deficient practice?** *The portable ABC type fire extinguisher in the Therapy Room in the Rehabilitation Wing has had its monthly inspection for October. **2. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *Residents, staff, and visitors in the Therapy Room in the Rehabilitation Wing have the potential to be affected by the alleged deficient practice. *All ABC type fire extinguishers have been audited by Maintenance Director/Designee to ensure they have had their monthly inspections completed. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *Maintenance Director/Designee will audit all ABC type fire extinguishers to ensure they are inspected monthly.	10/27/2016

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	the Therapy Room of the Rehabilitation Wing had an inspection tag affixed to the extinguisher which indicated an annual inspection was conducted in January 2016. However, a monthly inspection was not documented for September 2016. Based on interview at the time of observation, the Director of Maintenance stated no other monthly fire extinguisher inspection documentation was available for review and acknowledged a monthly inspection for the aforementioned portable fire extinguisher was not documented for September 2016. 3.1-19(b)		*Maintenance Director/Designee Director will be educated by October 27, 2016 by Administrator/Designee on ensuring all ABC type fire extinguishers are inspected monthly. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** *Fire Extinguisher CQI will be completed monthly x 4, and quarterly thereafter until compliance is at 100% by Maintenance Director/Designee. *The results of these audits will be reviewed by the Quality Assurance Committee monthly times 4, and quarterly thereafter until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	