STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	09/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(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: 09/27/17 Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490 At this Life Safety Code survey, Carmel Health & 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 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial walkout lower level was determined to be of Type V (111) construction and fully sprinklered except for the closet for the SDC Office near the classroom on the lower level, the closet for the Director of Environmental Services on the lower level and the timeclock closet in the Breakroom. The facility has a fire alarm	K 0000	**This plan of correction is to serve as Carmel Health and Living Community's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Carmel Health and Living or its management company that the allegations contained in the survey report are a true and accurate portrayal of the other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. In lieu of a post-survey re-visit the community respectfully requests a desk review.**	

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

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	system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in resident sleeping rooms in the 700 and 800 Hall. The facility has battery operated smoke detectors in resident sleeping rooms in the 200, 300, 400 and 500 Hall. The facility has a capacity of 188 and had a census of 130 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review by Lex Brashear, Life Safety Code Specialist on 10/04/17			
K 0132 SS=E Bldg. 01	NFPA 101 Multiple Occupancies - Contiguous Non-Health Multiple Occupancies - Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than 2-hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy			

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	regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1 Based on observation and interview, the facility failed to maintain the 2-hour fire rated separation between the skilled nursing unit and the independent living areas in accordance with Section 19.1.3.4.1. This deficient practice could affect over 40 residents, staff and visitors. Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:30 a.m. to 3:35 p.m. on 09/27/17, three of three corridor door sets in the tenant separation fire barrier wall between the skilled nursing unit and independent living were not equipped with fire rated latching hardware. Each of the corridor door sets by Room 201, by the Station 2 nurse's station and by Room 227 were magnetically locked and could be opened by entering a four digit code but were not equipped with fire rated positive latching hardware. Based on interview at the time of the observations, the Environmental Director stated the tenant separation door sets have never had latching hardware and were not equipped with positive latching devices. 3.1-19(b)	K 0132	**K132** **1.The facility ordered and will install the required latching hardware on each of the identified areas.** **2.All facility inspection of all doors was conducted to ensure proper fire rated latching hardware.** **3.Maintenance Supervisor/Designee will conduct a monthly inspection of each door. Additionally, an annual inspection of each door will be conducted by a qualified inspector to ensure compliance.** **4.Administrator/Designee will audit systematic changes utilizing an audit tool weekly for 4 weeks, bi-weekly for 2 months then monthly for 3 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	10/27/2017
K 0200	NFPA 101			

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SS=E Bldg. 01	Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 Based on observation and interview, the facility failed to ensure 4 of 4 corridor doors were provided with door latches requiring only one operation to open. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.10.2 requires the releasing mechanism shall open the door leaf with not more than one releasing operation. This deficient practice could affect five residents, staff and visitors. Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:30 a.m. to 3:35 p.m. on 09/27/17, the kitchen door by the elevator, the corridor door to the Therapy Room by the Pub and each of two corridor doors to the Family Conference Room were equipped with an independent thumb latch deadbolt in addition to the door handle which each latched into the door frame. Based on interview at the time of the observations,	K 0200	**1.The four dead bolts were removed.** **2.All facility inspection of all doors was completed to ensure compliance.** **3.Maintenance Supervisor/Designee will conduct monthly inspections to ensure doors with latches only require one operation to open.** **4.Administrator/Designee will audit systematic changes utilizing an audit tool weekly for 4 weeks, bi-weekly for 2 months then monthly for 3 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	10/27/2017

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	the Environmental Director agreed the aforementioned doors had an independent dead bolt in addition to the door handle. 3.1-19(b)			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements 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			

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	systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 2 of 17 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. 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 unless otherwise permitted by LSC	K 0222	**1.The codes were posted on the two identified exits.** **2.All facility inspection of all exits was completed to ensure posting compliance.** **3.Maintenance Supervisor/Designee will conduct monthly inspections to verify postings** **4.Administrator/Designee will audit systematic changes utilizing an audit tool weekly**	10/27/2017

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	19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:30 a.m. to 3:35 p.m. on 09/27/17, the ramp exit door near the Station 5 nurse's station and the exit door by Room 221 were each marked as a facility exit, were magnetically locked and could be opened by entering a four digit code but the code to open the door was not posted at the exit. Based on interview at the time of the observations, the Environmental Director stated the facility does not have a dedicated smoke compartment to house residents with a clinical diagnosis requiring specialized security measures and stated the aforementioned facility exits were marked as a facility exit and could be opened by entering a four digit code but the code was not posted. 3.1-19(b)		**for 4 weeks, bi-weekly for 2 months then monthly for 3 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC			

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	Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation and interview; the facility failed to ensure preventative maintenance for 1 of 91 battery operated smoke alarms in resident rooms was performed. 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 20 residents, staff, and visitors in the vicinity of Room 330. Findings include: Based on review of the facility's "Smoke Detector Inspection Schedule Battery Smoke Detector" documentation within the most recent twelve month period with the Environmental Director during record review from 9:10 a.m. to 11:30 a.m. on 09/27/17, the facility has battery operated smoke detectors in resident sleeping rooms in the 200, 300, 400 and 500 Hall which were documented as functionally tested and cleaned on a weekly basis. Based on observations with the Environmental Director during a tour of the facility from 11:30 a.m. to 3:35 p.m. on 09/27/17, a mounting plate for a	K 0300	**1.The smoke detector had just been removed by maintenance staff to replace the battery. The battery was replaced the detector was placed in room 330.** **2. All facility inspection of all battery-operated smoke detectors was completed to ensure compliance.** **3.Maintenance staff will bring the batteries and needed supplies to the rooms where the smoke detectors are located as opposed to taking the smoke detector to the maintenance shop for repair/cleaning.** **4.Administrator/Designee will audit systematic changes utilizing an audit tool weekly for 4 weeks, bi-weekly for 2 months then monthly for 3 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	10/27/2017

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	battery operated smoke detector was installed on the wall near the entry door to Room 330 but the plate was missing its battery operated smoke detector. Based on interview with the resident in the room in the bed nearest the window stated maintenance came to replace the battery a few days ago but took the detector and never returned. Based on interview at the time of record review, the Environmental Director stated all resident rooms in the 300 Hall should be equipped with battery operated smoke detector, all battery operated smoke detectors are tested and cleaned on a weekly basis but was unaware Room 330 was currently missing its battery operated smoke detector. 3.1-19(b)			
K 0311 SS=D Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the	K 0311	**1.A door with a fire rating of**	10/27/2017

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	facility failed to maintain protection of 1 of 2 interior stairwells. LSC 19.3.1 requires vertical openings shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.6.5 states see 7.1.3.2.1 for enclosures of exits. LSC 7.1.3.2.1 states the separation shall have a minimum 1-hr fire resistance rating where the exit connects three stories or less. Existing penetrations shall be protected in accordance with 8.3.5. This deficient practice could affect 5 staff and visitors on the lower level. Findings include: Based on observation with the Environmental Director at 10:04 a.m. on 09/27/17, the lower level stairwell door by the gold elevator was equipped with a 20 minute fire resistance label. Based on interview at the time of observation, the Environmental Director agreed the aforementioned stairwell door did not maintain the minimum 1-hour fire resistance rating for the stairwell. 3.1-19(b)		**at least an hour was ordered and will be installed in the identified area** **2. All facility inspection of all stairwell doors was completed to ensure compliance.** **3.Maintenance Director/designee will conduct monthly inspections of stairwell doors to ensure the fire rating is at least one hour.** **4.Administrator/Designee will audit systematic changes utilizing an audit tool weekly for 4 weeks, bi-weekly for 2 months then monthly for 3 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish			

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	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 over 100 rooms were provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility. LSC 3.3.90.4 defines interior wall finish as the interior finish of columns, fixed or movable walls, and fixed or movable partitions. 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 over 30 residents, staff and visitors. Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:30 a.m. to 3:35 p.m. on 09/27/17, the ceiling of the Electrical Panels Room by the Station 5 nurse's station consisted of a four foot by eight foot section of exposed wood paneling and wood studs. In addition, three of the	K 0331	**1.The ceiling of the Electrical Panels room and the walls of the Camera Room were dry-walled.** **2. All facility inspection ceilings and walls was completed to ensure compliance.** **3.Maintenance Supervisor/Designee will complete a monthly inspection to ensure compliance** **4. Administrator/Designee will audit systematic changes utilizing an audit tool weekly for 4 weeks, bi-weekly for 2 months then monthly for 3 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	10/27/2017

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	four walls of the Camera Room consisted of exposed wood studs. Based on interview at the time of the observations, the Environmental Director stated the flame spread rating for the wood paneling and wood studs was not available for review. 3.1-19(b)			
K 0351 SS=D Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)			
	1. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems,	K 0351	**1.Automatic sprinkler heads were installed in the SDC office closet, the Director of Environmental Services' closet, and the timeclock closet in the Breakroom, and**	10/27/2017

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	to provide complete coverage for all portions of the building. This deficient practice could affect 10 staff and visitors. Findings include: Based on observation with the Environmental Director during a tour of the facility at 10:02 a.m. on 09/27/17, the closet for the SDC Office near the classroom on the lower level was not provided with a sprinkler. At 10:15 a.m., the closet for the Director of Environmental Services on the lower level was also not provided with a sprinkler. At 2:00 p.m., the timeclock closet in the Breakroom was also not provided with a sprinkler. Based on interview at the time of the observations, the Environmental Director agreed the aforementioned areas were each not provided with a sprinkler. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 electrical panel rooms. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above		**the ceiling tile was replaced and fire caulked.** **2.All facility inspection of all sprinkler heads completed to ensure compliance.** **3.Maintenance Supervisor/ Designee will conduct monthly inspections to ensure compliance.** **4.Administrator/Designee will audit systematic changes utilizing an audit tool weekly for 4 weeks, bi-weekly for 2 months then monthly for 3 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	

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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
	shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the Electrical Panel Room by the Station 2 nurse's station. Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:30 a.m. to 3:35 p.m. on 09/27/17, one suspended ceiling tile was missing in the Electrical Panel Room by the Station 2 nurse's station. Over twenty cables penetrated the opening left by the missing tile which exposed the ceiling above. The room was equipped with pendant sprinklers installed on the suspended ceiling. Based on interview at the time of the observations, the Environmental Director acknowledged the missing ceiling tile in the aforementioned room. 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,			

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	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 provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. 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, 2011 Edition, Section 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. Section 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	K 0353	**K353** **1.The facility has ensured that the sprinkler system components have been inspected and tested quarterly. Items in the activities closet have been removed to ensure an 18-inch clearing from the ceiling.** **2.The Maintenance Director has verified the testing schedule with the contracted company. Full house inspection was conducted to ensure an 18-inch clearing from the ceiling.** **3.Maintenance Supervisor/ Designee will conduct monthly inspections to ensure compliance.** **4.Administrator/Designee will audit systematic changes utilizing an audit tool weekly for 4 weeks, bi-weekly for 2 months then monthly for 3 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee**	10/27/2017

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	the date. Section 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. Section 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. Section 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of P.I.P.E.'s "Report of Inspection" documentation dated 03/27/17 and I.E.I.'s "Form for Inspection, Testing, and Maintenance of Wet (Dry) Pipe Fire Sprinkler Systems" dated 07/11/17 with the Environmental Director during record review from 9:10 a.m. to 11:30 a.m. on 09/27/17, quarterly sprinkler system inspection documentation for the wet and dry sprinkler systems for the second quarter (April, May, June) 2017 was not available for review. Based on interview at the time of record review, the Environmental Director stated the facility switched sprinkler system contractors earlier this year and additional quarterly sprinkler inspection documentation for		**meeting and frequency and duration of the reviews will be adjusted as needed.**	

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	the second quarter 2017 was not available for review. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure clearance of at least 18 inches was maintained below the level of the sprinkler deflectors in 1 of 1 Activity Rooms. NFPA 25, 2011 Edition, Section 5.2.1.2 states the minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Activities Room. Finding includes: Based on observations with the Environmental Director during a tour of the facility from 11:30 a.m. to 3:35 p.m. on 09/27/17, board game boxes and a plastic bag filled with activity items were stored on the top shelf of the Activities Room closet within one inch of the ceiling. Based on interview at the time of the observations, the Environmental Director agreed items stored in the aforementioned closet provided sprinkler spray pattern obstruction less than 18 inches from the ceiling.			

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	3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of over 100 sprinklers were replaced or cleaned in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect 5 staff and visitors on the lower level. Findings include:			

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	Based on observation with the Environmental Director at 10:11 a.m. on 09/27/17, the sprinkler located in the furnace closet of the lower level Medical Record Room was corroded. Based on interview at the time of observation, the Environmental Director agreed the aforementioned sprinkler location was corroded. 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 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.			

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	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 4 of over 100 corridor doors had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:30 a.m. to 3:35 p.m. on 09/27/17, the following was noted: a. the corridor door to Room 214 was propped in the half open position with a wedge placed on the floor under the door. b. a three quarter inch gap was noted in between the top of the door and the door jamb on the handle side of the door to Room 301. c. the cubicle curtain for the resident bed	K 0363	**1.The wedges in rooms 214 and 825 were removed. A door was ordered and will be installed in room 301. The track was replaced for the cubicle curtain.** **2.Full house audit performed to ensure compliance with regulation** **3.Maintenance Supervisor/ Designee will conduct monthly inspections to ensure compliance.** **4.Administrator/Designee will audit systematic changes utilizing an audit tool weekly for 4 weeks, bi-weekly for 2 months then monthly for 3 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	10/27/2017

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	when stored at the end of the curtain track by the corridor door prevents the door from closing and latching into the door frame. d. the corridor door to Room 825 was propped in the fully open position with a wedge placed on the floor under the door. Based on interview at the time of the observations, the Environmental Director agreed the aforementioned corridor doors had an impediment to closing and latching or would not resist the passage of smoke. 3.1-19(b)			
K 0372 SS=D 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 1 of 2 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance	K 0372	**1.The holes were repaired in the closet of the Environmental Service Office, the Medical Supply Office, and the**	10/27/2017

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	rating. This deficient practice could affect 5 staff on the lower level. Findings include: Based on observation with the Environmental Director at 10:15 a.m. on 09/27/17, a two inch hole was noted in the ceiling of the closet of the Environmental Service Office on the lower level. At 10:30 a.m., a four inch by four inch hole was noted in the ceiling of the Medical Supply Office on the lower level where a light fixture had been removed. In addition, a one half inch in diameter hole was noted in the ceiling of the room for the passage of a blue cable which was not firestopped. Based on interview at the time of the observations, the Environmental Director agreed the aforementioned holes did not maintain the fire resistance rating of the lower level ceiling smoke barrier. 3.1-19(b)		**identified ceiling.** **2.Full house inspection completed to ensure compliance.** **3.Maintenance Supervisor/ Designee will conduct monthly inspections to ensure compliance.** **IV. Administrator/Designee will audit systematic changes utilizing an audit tool weekly for 4 weeks, bi-weekly for 2 months then monthly for 3 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	
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			

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	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 21 sets of corridor doors would close to form a smoke resistant barrier. Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors which swing in the same direction and equipped with an astragal to have a coordinator to ensure the door which must close first always closes first. This deficient practice could affect 20 residents, staff and visitors. Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:30 a.m. to 3:35 p.m. on 09/27/17, the set of corridor doors serving as the south entrance to the Therapy Room and the set of corridor doors by Room 331 each swing in the same direction and were equipped with an astragal. Each door set was not equipped with a door closing coordinator to ensure the door equipped with an astragal closes last and forms a smoke	K 0374	**1.The coordinator was ordered and will be installed to ensure the door which must close first closes first.** **2.Full house inspection completed to ensure compliance.** **3.Maintenance Supervisor/ Designee will conduct monthly inspections to ensure compliance.** **4.Administrator/Designee will audit systematic changes utilizing an audit tool weekly for 4 weeks, bi-weekly for 2 months then monthly for 3 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	10/27/2017

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	resistant barrier. Based on interview at the time of observation, the Environmental Director agreed the aforementioned corridor door sets were not equipped with a door closing coordinator to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier. 3.1-19(b)			
K 0916 SS=E Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 2 of 3 emergency generator annunciator panels were in proper operating condition. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:30 a.m. to 3:35 p.m.	K 0916	**K916** **1.The maintenance director will install a locked cover to prevent unauthorized silencing of the annunciator.** **2.Full house inspection completed to ensure compliance.** **3.Maintenance Supervisor/ Designee will conduct daily inspections to ensure compliance.** **4.Administrator/Designee will**	10/27/2017

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	on 09/27/17, the facility has three emergency generators and the horn switch for Emergency Generator II annunciator panel at the Station 2 nurse's station and the horn switch for Emergency Generator III annunciator panel at the Station 5 nurse's station were both in the off position. Based on interview at the time of the observations, the Environmental Director stated each emergency generator was not currently undergoing load testing and the horn switch should have been reset to the on position after the most recent load tests were conducted. 3.1-19(b)		**audit systematic changes utilizing an audit tool weekly for 4 weeks, bi-weekly for 2 months then monthly for 3 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	
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			

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	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, the facility failed to ensure 4 of 4 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 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, 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,	K 0920	**1.The protectors in rooms 201, 309, 735, and 817 were replaced and mounted.** **2.Full house inspection completed to ensure compliance.** **3.Maintenance Supervisor/ Designee will conduct monthly inspections to ensure compliance.** **4.Administrator/Designee will audit systematic changes utilizing an audit tool weekly for 4 weeks, bi-weekly for 2 months then monthly for 3 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	10/27/2017

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	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. NFPA 99, Section 10.4.2.3 states household or office 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 over 20 residents, staff and visitors. Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:30 a.m. to 3:35 p.m. on 09/27/17, the following was noted: a. the resident bed was plugged into a power strip underneath the bed in Room 201. b. a refrigerator, a light and a telephone charger were plugged into a power strip located three feet from the resident bed nearest the corridor door in Room 309. c. a light was plugged into a power strip underneath the resident bed in Room 735. d. a Power Neb Ultra medical device, a toaster and a coffee pot were plugged into a power strip one foot from the resident bed in Room 817. The UL listing for each of the aforementioned power strips could not be determined. Based on interview at the			

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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
	time of the observations, the Environmental Director agreed a power strip was being used as a substitute for fixed wiring in the patient care vicinity at the aforementioned locations. 3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO			

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	155181	A. BUILDING 01 B. WING	09/27/2017

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	SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	1. Based on observation and interview, the facility failed to ensure 1 of 1 storage locations for nonflammable gases equal to or greater than 3000 cubic feet was in accordance with NFPA 99, Health Care Facilities Code. NFPA 99, 2012 Edition, Section 11.3.1 states storage locations for nonflammable gases equal to or greater than 3000 cubic feet shall comply with Section 5.1.3.3.2 and Section 5.1.3.3.3. Section 5.1.3.3.2(4) states the storage locations of positive-pressure gases, if indoors, they shall be constructed and use interior finishes of noncombustible or limited-combustible materials such that all walls, floors, ceilings, and doors are of a minimum 1-hour fire resistance rating. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the oxygen storage room and transfilling room. Findings include:	K 0923	**1.The ceiling was drywalled in the oxygen storage room, and the oxygen tanks were removed from room 306 and storage room.** **2.Full house inspection completed to ensure compliance.** **3.Maintenance Supervisor/ Designee will conduct weekly inspections to ensure compliance.** **4.Administrator/Designee will audit systematic changes utilizing an audit tool weekly for 4 weeks, bi-weekly for 2 months then monthly for 3 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	10/20/2017

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	Based on observations with the Environmental Director during a tour of the facility from 11:30 a.m. to 3:35 p.m. on 09/27/17, the interstitial space between the metal roof deck and the top of the three walls opposite the rolling garage door of the oxygen storage and transfilling room were filled with fiberglass. In addition, the exposed metal roof deck above the room serving as the ceiling for the room was not protected with fire resistive construction. Fourteen liquid oxygen containers and six 'E' cylinders were stored in the room. Based on interview at the time of the observations, the Environmental Director stated fire resistance rating documentation for the fiberglass was not available for the room and it could not be assured the room was enclosed with 1 hour fire resistive construction. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 containers of nonflammable gases such as oxygen were stored in locations that can be secured against unauthorized entry. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic			

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	feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.1 states storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. This deficient practice could affect 20 residents, staff and visitors in the vicinity of Room 306. Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:30 a.m. to 3:35 p.m. on 09/27/17, one liquid oxygen containers were stored in resident Room 306. No residents were noted in the room and the container was not in use by a resident. Based on interview at the time of the observations, the Environmental stated the oxygen container had been used by the resident in Room 306 but has been stored in the room since the resident left for the hospital approximately three weeks ago. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 cylinders in 1 of 3 nonflammable gas			

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	storage locations were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect five staff on the lower level. Findings include: Based on observation with the Environmental Director at 10:43 a.m. on 09/27/17, one of three 'E' type oxygen cylinders was standing upright on the floor of the adult diaper storage room on the lower level and was not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the Environmental Director stated he was not sure why the cylinders were stored in the room and one of the cylinders was not properly chained or supported in a proper cylinder stand or cart.			

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	3.1-19(b)			
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)			
	Based on record review, observation and interview; the facility failed to ensure 1 of 1 oxygen storage locations where transfilling occurs was in accordance with NFPA 99, Health Care Facilities Code. NFPA 99, 2012 Edition, Section 11.5.2.3.1 states oxygen transfilling locations shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire resistive construction. (2) The area is mechanically vented, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is	K 0927	**1.The ceiling was drywalled in the oxygen storage room.** **2.Full house inspection completed to ensure compliance.** **3.Maintenance Supervisor/ Designee will conduct weekly inspections to ensure compliance.** **4.Administrator/Designee will audit systematic changes utilizing an audit tool weekly for 4 weeks, bi-weekly for 2 months then monthly for 3 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.**	10/27/2017

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	not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures. Section 11.5.3.2.1 states in health care facilities where smoking is not prohibited, precautionary signs readable from a distance of 1.5 m (5 ft) shall be conspicuously displayed wherever supplemental oxygen is in use and in aisles an walkways leading to such an area. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the oxygen storage room and transfilling room. Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:30 a.m. to 3:35 p.m. on 09/27/17, the interstitial space between the metal roof deck and the top of the three walls opposite the rolling garage door of the oxygen storage and transfilling room were filled with fiberglass. In addition, the exposed metal roof deck above the room serving as the ceiling for the room was not protected with fire resistive construction. Fourteen liquid oxygen containers and six 'E' cylinders were stored in the room. Based on interview at the time of the observations, the Environmental Director			

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	stated fire resistance rating documentation for the fiberglass was not available for the room and it could not be assured the transfilling room was enclosed with 1 hour fire resistive construction. 3.1-19(b)			