

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2018
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP COD 3175 LANCER ST PORTAGE, IN 46368
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E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 03/05/18</p> <p>Facility Number: 000098 Provider Number: 155187 AIM Number: 100290980</p> <p>At this Emergency Preparedness survey, Golden Living Center - Fountainview was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73</p> <p>The facility has 186 certified beds. At the time of the survey, the census was 134.</p> <p>Quality Review completed on 03/13/18 - DA</p> <p>The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:</p>	E 0000	<p>This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements The facility respectfully request paper compliance Thank you for your consideration,</p> <p>Respectfully, Jason Eastlund, BSW, HFA</p>	
E 0022 SS=C Bldg. --	<p>Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for residents, staff, and volunteers who remain in the LTC facility in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all occupants.</p>	E 0022	<p>Facility updated Policy and Procedure for Sheltering in place Facility emergency preparedness plan was reviewed to ensure appropriate policies existed Executive director and Maintenance department were educated on E 022</p>	04/04/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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E 0039 SS=C Bldg. --	<p>Findings include:</p> <p>Based on record review and interview with the Executive Director and the Maintenance Supervisor on 03/05/18 at 11:35 a.m., a policy and procedure that included a means to shelter in place for residents, staff, and volunteers who remain in the LTC facility was not available for review.</p> <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as</p>	E 0039	<p>Facility will monitor annually to ensure testing is performed per standard. All negative findings will be reviewed in Monthly QAPI meeting</p> <p>Facility utilized an elopement and a power outage that was reported to ISDH as examples of testing but this did not meet standard. Facility ran mock fire drill prior to date of compliance. Executive director and Maintenance department were educated on E 039 Executive director and Maintenance department were educated on E 039 Facility will monitor annually to ensure testing is performed per standard. All negative findings will be reviewed in Monthly QAPI meeting</p>	04/04/2018	

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K 0000 Bldg. 01	<p>needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review and interview with the Executive Director and the Maintenance Supervisor on 03/05/18 at 12:00 p.m., no full-scale exercise and testing drill of emergency preparedness was available for review.</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 03/05/18</p> <p>Facility Number: 000098 Provider Number: 155187 AIM Number: 100290980</p> <p>At this Life Safety Code survey, Golden Living Center-Fountainview was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 483.90(a), Life Safety from Fire, the 2012 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code), and 410 IAC 16.2. The original building 0102 consists of everything except the 300 wing Rehabilitation unit and was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>The facility was surveyed as two separate buildings because of the construction dates of two sections of the building. Building 0102 built prior to March, 1 2003 was determined to be of</p>	K 0000	<p>This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements The facility respectfully request paper compliance Thank you for your consideration, Respectfully, Jason Eastlund, BSW, HFA</p>	

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K 0211 SS=E Bldg. 01	<p>Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident rooms. The facility has a capacity of 186 and had a census of 134 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has three detached buildings providing facility storage services which were not sprinklered.</p> <p>Quality Review completed on 03/13/18 - DA</p> <p>NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1</p> <p>Based on observation and interview, the facility failed to maintain 3 of 11 corridors and 1 of 18 exit discharges from obstructions per 19.2.1 LSC 19.2.1 states that every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. LSC 7.1.10. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. LSC 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits or their access thereto, egress therefrom, or visibility thereof. This deficient practice could affect staff and up to</p>	K 0211	<p>Facility removed obstructions prior to date of compliance Facility wide search conducted to identify any potential hazards not mentioned in survey Staff education conducted to ensure understanding of K 211 prior to date of compliance Facility to audit for obstruction 1 X per week for 4 weeks, 1 X per month for 3 months, then quarterly until facility is 95% substantial compliant. All negative findings will be</p>	04/04/2018

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K 0221 SS=D Bldg. 01	<p>28 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/05/18 between 12:26 p.m. and 2:17 p.m., the following was stored in the corridor:</p> <ul style="list-style-type: none"> a) two soiled linen carts outside the 100 Hall soiled utility with no housekeeping staff present b) two soiled linen carts outside the 100 Hall shower room with no housekeeping staff present c) a warming cart was on the exit discharge path outside the Assisted Dining room d) a welcome cart with a plant was in the corridor outside the Medical Records office e) ten pieces of firewood and a sled was in the corridor by resident room 313 <p>Based on interview at the time of each observation, the Maintenance Supervisor acknowledged that the aforementioned storage items were potential impediments to full use of the means of egress access and exit discharges.</p> <p>3.1-19(b)</p> <p>NFPA 101 Patient Sleeping Room Doors Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4</p> <p>Based on observation, the facility failed to ensure 1 of 2 Front Entrance Bathrooms locked doors could be readily unlocked in accordance with LSC 19.2.2.2.6 which allows doors that are located in</p>	K 0221	<p>addressed in monthly qapi meeting.</p> <p>Facility immediately removed the chain lock on the inside door of the mens visitor bathroom. Facility audited the women's</p>	04/04/2018	

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K 0222 SS=F Bldg. 01	<p>the means of egress and are permitted to be locked under other provisions of 19.2.2.2.5 shall comply with the following. (1) Provisions shall be made for the rapid removal of occupants by means of one of the following: (a) Remote control of locks (b) Keying of all locks to keys carried by staff at all times (c) Other such reliable means available to the staff at all times. This deficient practice could affect staff and up to 1 resident.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/05/18 at 4:27 p.m., the Front Entrance Men's bathroom contained a chain lock. Based on interview at the time of observation, the Maintenance Supervisor confirmed that the chain lock was installed on the door.</p> <p>3.1-19(b)</p> <p>NFPA 101 Egress Doors Egress Doors</p> <p>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</p> <p>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.</p>		<p>visitor bathroom to ensure compliance. Maintenance Dept educated on K 221 Facility will audit the bathroom 1 X per week for 4 weeks, 1 X per month for 3 months, then quarterly until facility is 95% substantial compliant. All negative findings will be addressed in monthly QAPI meeting</p>	

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	<p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p> <p>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.</p> <p>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.</p> <p>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</p>			

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	<p>on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p>1. Based on observation, record review, and interview, the facility failed to ensure 15 of 18 exits had a correct code posted. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. LSC 19.2.2.2.5.2 requires 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 all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/05/18 between 12:04 p.m. and 4:41 p.m., all exit doors were held in the locked position with a magnetic hold down device. Furthermore, the exit door was equipped with an electronic keypad entry system that allowed staff to open the locked exit doors with a combination. A code was posted at each exit door but would not unlock the doors. Based on an interview at the time of observation, the Maintenance Supervisor confirmed the code to unlock the doors was not posted.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of</p>	K 0222	<p>All affected doors were fitted with the appropriate signage to operate according to guideline and exit door next to 201 was adjusted to meet standard of operating 15 seconds after pushing.</p> <p>All doors were assessed to identify any others that did not meet expectations.</p> <p>Maintenance department educated on K 222</p> <p>Facility to monitor doors 1 X per week for 4 weeks, 1 X per month for 3 months, then quarterly until facility is 95% substantial compliant.</p> <p>All negative findings will be reviewed in Monthly QAPI meeting</p>	04/04/2018

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K 0293 SS=E Bldg. 01	<p>18 exits were readily accessible for residents. This deficient practice could affect staff and up to 22 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/05/18 at 12:20 p.m., the Maintenance Supervisor was unable to open the exit door near Activities. Based on interview at the time of the observations, the Maintenance Supervisor confirmed the door would not open.</p> <p>3.1-19(b)</p> <p>NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on record review and interview; the facility failed to install exit signage in 1 of 11 corridors in the facility in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. This deficient practice could affect staff and at least 10 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance</p>	K 0293	<p>Upon review, maintenance Director had forgotten that facility placed sidewalk that connects to out back parking lot. The sidewalk runs along the back side of our ACE unit, which is fenced. No other sidewalks were identified as having issues. Maintenance director educated on K 293 Facility to monitor doors 1 X per week for 4 weeks, 1 X per month for 3 months, then quarterly until</p>	04/04/2018

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K 0324 SS=E Bldg. 01	<p>f. Combustible Storage Rooms/Spaces (over 50 square feet)</p> <p>g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>Based on observation and interview, the facility failed to maintain protection of 1 of 1 Laundry in accordance of 19.3.2. LSC 19.3.2, Protection from Hazards, requires doors to be self-closing or automatic closing. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/05/18 at 3:31 p.m. then again at 4:34 p.m., the Laundry contained fuel-fired equipment. The Laundry room contained double corridor doors. the South East set of double doors contained an astragal, but no coordinating device installed. Centers for Medicare & Medicaid Services (CMS) requires sets of 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. Then again, when the fire alarm was activated, the North East Laundry double doors released with the fire alarm but failed to latch into the frame. Based on interview at the time of observation, the Maintenance Supervisor acknowledged one set of doors was missing a coordinating device and the other set failed to latch into the frame when tested.</p> <p>3.1-19(b)</p> <p>NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for</p>	K 0321	<p>Mentioned doors were adjusted to ensure latching and a coordinator was placed on the doors that contained an astragal</p> <p>All other doors were assessed to ensure standard was met</p> <p>Maintenance Dept was educated on K 321</p> <p>Facility to monitor doors 1 X per week for 4 weeks, 1 X per month for 3 months, then quarterly until facility is 95% substantial compliant.</p> <p>All negative findings will be reviewed in monthly QAPI meeting</p>	04/04/2018

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	<p>Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 1. Based on record review and interview, the facility failed to ensure 1 of 1 Activities kitchen was provided with a fire suppression system per NFPA 96. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 4.1.1 requires cooking equipment that produces grease-laden vapors shall be equipped with an exhaust system that complies with all the equipment and performance requirements of this standard. This deficient practice affects staff and up to 8 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/05/18 at 1:43 p.m., the Activities kitchen had a residential stove without a fire suppression system. Based on interview at the time of observation, the CNA/ Activity Assistant #1 confirmed that the stove has been used to</p>	K 0324	<p>Facility has stopped cooking bacon and sausage for residents in the activity room. Dietary Manager was educated on K 324 All stoves were observed to ensure appropriate ventilation was in place for cooking purposes. Maintenance, Activity and kitchen departments were educated on K 324.</p> <p>Facility will monitor cooking and staff awareness of what to do if a grease fire happened under the hood 1 X per week for 4 weeks, 1 X per month for 3 months, then quarterly until facility is 95% substantial compliant.</p> <p>All negative findings will be reviewed in Monthly QAPI meeting.</p>	04/04/2018
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP COD 3175 LANCER ST PORTAGE, IN 46368
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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
K 0353 SS=D Bldg. 01	<p>cook bacon and sausage for the residents with some regularity. The Maintenance Supervisor acknowledged the cooking being performed.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/05/18 at 3:14 p.m., the Kitchen contained a UL 300 hood system. Based on interview, the Dining Service Manager was asked what she would do if there was a grease fire underneath the hood. She replied she would grab the K class fire extinguisher then go and pull the fire alarm pull station. She failed to indicate pulling the Ansul hood pull station. Based on interview, the Maintenance Supervisor acknowledged her response and confirmed that he will instruct all kitchen staff on proper response.</p> <p>3.1-19(b)</p> <p>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.</p>			

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K 0355 SS=D Bldg. 01	<p>Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>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</p> <p>Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 Ambulance Entrance. 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 shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect staff and up to 1 resident.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/05/18 at 3:36 p.m., a ceiling tile was missing near the Ambulance Entrance. Based on interview at the time of observation, the Maintenance Supervisor was unaware of the missing ceiling tile.</p> <p>3.1-19(b)</p> <p>NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected,</p>	K 0353	<p>Facility replaced the tile near the ambulance entrance, prior to date of compliance</p> <p>Facility assessed to identify any other missing tiles that could affect the sprinkler system</p> <p>Maintenance department educated on K 353</p> <p>Facility will monitor the affected area 1 X per week for 4 weeks, 1 X per month for 3 months, then quarterly until facility is 95% substantial compliant.</p> <p>All negative findings will be reviewed in monthly QAPI meeting</p>	04/04/2018

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K 0361 SS=E Bldg. 01	<p>installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10</p> <p>Based on observation, interview and record review, the facility failed to maintain 1 of 2 Kitchen portable fire extinguishers was maintained correctly in accordance with 19.3.5.12. NFPA 10, the Standard for Portable Fire Extinguishers, 7.3.1.2.1 Six-Year Internal Examination. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable internal examination procedures as detailed in the manufacturer's service manual and this standard. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/05/18 at 3:21 p.m., the Kitchen class ABC fire extinguisher manufacturer date printed on the bottom of the extinguisher was 01/12. The fire extinguisher did not have a neck collar provided. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition and confirmed the fire extinguisher is over six years old without an internal inspection.</p> <p>3.1-19(b)</p> <p>NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1</p>	K 0355	<p>The extinguisher in question was replaced prior to date of compliance</p> <p>All extinguishers were reviewed to ensure that the internal inspection date was appropriate.</p> <p>Maintenance department was educated on K 355</p> <p>Facility will monitor all extinguishers 1 X per week for 4 weeks, 1 X per month for 3 months, then quarterly until facility is 95% substantial compliant.</p> <p>All negative findings will be reviewed in monthly QAPI meeting</p>	04/04/2018

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K 0363 SS=E Bldg. 01	<p>and 19.3.6.1. 18.3.6.1, 19.3.6.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 300 Hall corridor was separated from the corridors by a partition capable of resisting the passage of smoke in accordance with 19.3.6.1. This deficient practice could affect staff and at least 6 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/05/18 at 2:49 p.m., the corridor near resident room 333 had six separate penetrations ranging from a quarter inch to a half inch. Based on observation, the Maintenance Supervisor acknowledged the damaged drywall and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 Corridor - Doors Corridor - Doors</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p> <p>Clearance between bottom of door and floor</p>	K 0361	<p>Facility had the 6 passages fixed prior to date of compliance.</p> <p>All hall corridors were assessed to ensure standard is met.</p> <p>Maintenance department educated on F 361</p> <p>All hall corridors will be monitored 1 X per week for 4 weeks, 1 X per month for 3 months, then quarterly until facility is 95% substantial compliant.</p> <p>All negative findings will be reviewed in monthly QAPI meeting.</p>	04/04/2018
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	<p>covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>Based on observation and interview, the facility failed to maintain protection of corridor doors in 2 of 11 corridors in accordance of 19.3.6.3. This deficient practice could affect staff and at least 6 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/05/18 at 1:01 p.m. then again at 3:07 p.m., resident room 118 failed to latch into the frame when tested. Then again, the Business Center corridor door contained a plastic door stop. Based on interview at the time of each observation, the Maintenance Supervisor acknowledged the corridor doors had an</p>	K 0363	<p>Dorr 118 was adjusted and latched. The door stop was removed from the business office. All doors were assed to ensure latching and being free from door stops.</p> <p>Department heads were educated on K 363</p> <p>The affected areas will be monitored 1 X per week for 4 weeks, 1 X per month for 3 months, then quarterly until facility is 95% substantial compliant.</p> <p>All negative findings will be reviewed in Monthly QAPI meeting.</p>	04/04/2018

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K 0372 SS=F Bldg. 01	<p>impediment to closing and latching into the frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 9 of 12 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum 1/2 hour fire resistive rating. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 03/05/18 between 12:14 p.m. and 2:43 p.m., the following unsealed penetrations were discovered: a) a half inch gap inside conduit in the Front Entrance smoke barrier above the drop ceiling</p>	K 0372	<p>All affected areas were addressed prior to date of compliance. All other smoke barrier walls were assessed to ensure standard was met. Maintenance department were educated on K 372 The affected areas will be monitored 1 X per week for 4 weeks, 1 X per month for 3 months, then quarterly until facility is 95% substantial compliant. Any negative findings will be addressed in monthly QAPI meeting.</p>	04/04/2018

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K 0741 SS=D Bldg. 01	<p>b) a quarter inch to half inch gap around HVAC in the 100 Hall soiled utility smoke barrier above the drop ceiling</p> <p>c) a one inch gap inside conduit in the resident room 121 smoke barrier above the drop ceiling</p> <p>d) a three quarter inch gap inside conduit in the resident room 105 smoke barrier above the drop ceiling</p> <p>e) a quarter inch and a half inch penetration in the Director of Nursing smoke barrier above the drop ceiling</p> <p>f) a half inch penetration around conduit in the resident room 305 smoke barrier above the drop ceiling</p> <p>g) a two inch gap around HVAC in the resident room 310 smoke barrier above the drop ceiling</p> <p>h) a one and a half inch by ten inch penetration around HVAC in the resident room 319 smoke barrier above the drop ceiling</p> <p>i) a three quarter inch gap inside conduit in the resident room 329 smoke barrier above the drop ceiling</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with</p>			

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	<p>signs that read NO SMOKING or shall be posted with the international symbol for no smoking.</p> <p>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.</p> <p>(3) Smoking by patients classified as not responsible shall be prohibited.</p> <p>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.</p> <p>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</p> <p>18.7.4, 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for staff and residents was maintained in accordance with 19.7.4. LSC 19.7.4 requires ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. Metal containers with a self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. This deficient practice could affect staff and up to 1 resident.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 03/05/18 at 3:36 p.m., there were at least 60 cigarette butts on the ground by the Ambulance Entrance. Additionally, the surveyor witnessed a staff member flicking the cigarette in</p>	K 0741	<p>The affected area had cleaning conducted</p> <p>Facility searched to identify high concentrations of cigarette butts and addressed those areas</p> <p>Education provided to staff related to K 741</p> <p>The affected areas will be monitored 1 X per week for 4 weeks, 1 X per month for 3 months, then quarterly until facility is 95% substantial compliant. Any negative findings will be reviewed in Monthly QAPI meeting.</p>	04/04/2018

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K 0781 SS=D Bldg. 01	<p>the area of all the other cigarette butts on the ground. Based on interview at the time of observation, the Maintenance Supervisor provided the estimated number of cigarettes.</p> <p>3.1-19(b)</p> <p>NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation, interview, and record review, the facility failed to enforce 1 of 1 policy for the use of portable space heaters in accordance with 19.7.8. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/05/18 at 4:28 p.m., a space heater was discovered at the Receptionist area. Based on interview and record review at the time of observation, the Maintenance Supervisor acknowledged the space heater and confirmed that the facility's space heater policy does not allow space heaters in the facility.</p> <p>3.1-19(b)</p>	K 0781	<p>The identified space heater was removed from facility prior to date of compliance. Facility searched to identify any other deficient practices related to space heaters. The SDC provided education to staff related to K 781 prior to date of compliance. The affected areas will be monitored 1 X per week for 4 weeks, 1 X per month for 3 months, then quarterly until facility is 95% substantial compliant. All negative findings will be reviewed in Monthly QAPI meeting.</p>	04/04/2018
K 0920 SS=E Bldg. 01	<p>NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and</p>			

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	<p>Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 3 of 3 multiplug and 4 of 4 flexible cords were not used as a substitute for fixed wiring according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 35 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/05/18 between 12:34 p.m. and</p>	K 0920	<p>All mentioned areas were addressed to meet standard prior to date of compliance. Facility was searched to identify any other areas not mentioned in survey process. The SDC provided education to staff related to K 920 prior to date of compliance. The affected areas will be monitored 1 X per week for 4 weeks, 1 X per month for 3 months, then quarterly until facility is 95% substantial compliant. All negative findings will be addressed in Monthly QAPI</p>	04/04/2018
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	<p>3:45 p.m., the following was discovered:</p> <ul style="list-style-type: none"> a) a multiplug adapter was powering a television in resident room 132 b) a multiplug adapter was powering a surge protector powering a television in resident room 118. Additionally, a medical grade surge protector was powering another non-medical grade surge protector powering personal equipment. c) a multiplug adapter was powering a television in resident room 323 d) a surge protector was powering a microwave in the Unit Supervisor office <p>Based on interview at the time of each observation, the Maintenance Supervisor acknowledged each aforementioned condition and confirmed each device was improperly installed.</p> <p>3.1-19(b)</p> <p>2. Based on observation, record review, and interview, the facility failed to install 3 of 3 power strips according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 110.3(B) Installation and Use, states listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. This deficient practice affects staff and up to 28 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/05/18 at 1:14 p.m. and 1:27 p.m., the following was discovered:</p> <ul style="list-style-type: none"> a) a power strip was powering a bed in resident room 112 b) a power strip was powering a bed in resident room 105 		meeting.	

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K 0000 Bldg. 02	<p>c) a power strip was powering a bed air mattress in resident room 107</p> <p>Based on interview at the time of each observation, the Maintenance Supervisor was unable to provide UL 60601-1 documentation for the permanently installed power strips in each patient care area.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure electrical outlets were protected in 1 of 1 Storage room 302 according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(c) requires all junction boxes shall be provided with covers compatible with the box. Additionally, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/05/18 at 1:54 p.m., two separate outlets were missing a cover plate in Storage room 302. Based on interview at the time of observation, the Maintenance Supervisor acknowledged each missing outlet covers.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana</p>	K 0000	This plan of correction shall serve as this facilities' credible allegation	

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE			STREET ADDRESS, CITY, STATE, ZIP COD 3175 LANCER ST PORTAGE, IN 46368		
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	<p>State Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 03/05/18</p> <p>Facility Number: 000098 Provider Number: 155187 AIM Number: 100290980</p> <p>At this Life Safety Code survey, Golden Living Center-Fountainview was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 483.90(a) Life Safety from Fire, the 2012 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code), and 410 IAC 16.2. The 300 wing, Rehabilitation unit consisted of 14 additional beds and was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>The facility was surveyed as two separate buildings because of the construction dates of two sections of the building. Building 0202 built in 2005 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident rooms. The facility has a capacity of 186 and had a census of 134 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has three detached buildings providing facility storage services which were not sprinklered.</p> <p>Quality Review completed on 03/13/18 - DA</p>		<p>of compliance Preparation, submission, and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements The facility respectfully request paper compliance Thank you for your consideration,</p> <p>Respectfully, Jason Eastlund, BSW, HFA</p>		

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K 0211 SS=E Bldg. 02	<p>NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1</p> <p>Based on observation and interview, the facility failed to maintain 1 of 11 corridors from obstructions per 19.2.1 LSC 19.2.1 states that every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. LSC 7.1.10. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. LSC 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits or their access thereto, egress therefrom, or visibility thereof. This deficient practice could affect staff and up to 25 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/05/18 between 3:45 p.m. and 4:16 p.m., the following was stored in the corridor: a) two soiled linen carts outside resident room 233 with no housekeeping staff present b) a drawer was at the end of the corridor near resident room 206</p> <p>Based on interview at the time of each observation, the Maintenance Supervisor acknowledged that the aforementioned storage items were potential impediments to full use of the means of egress access and exit discharges.</p>	K 0211	<p>Facility removed obstructions prior to date of compliance Facility wide search conducted to identify any potential hazards not mentioned in survey Staff education conducted to ensure understanding of K 211 prior to date of compliance Facility to audit for obstruction 1 X per week for 4 weeks, 1 X per month for 3 months, then quarterly until facility is 95% substantial compliant. All negative findings will be addressed in monthly qapi meeting.</p>	04/04/2018			

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K 0222 SS=F Bldg. 02	<p>3.1-19(b)</p> <p>NFPA 101 Egress Doors Egress Doors</p> <p>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</p> <p>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</p> <p>SPECIAL NEEDS LOCKING ARRANGEMENTS</p> <p>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p>			

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	<p>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.</p> <p>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.</p> <p>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.</p> <p>18.2.2.2.4, 19.2.2.2.4 1. Based on observation, record review, and interview, the facility failed to ensure 3 of 18 exits had a correct code posted. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. LSC 19.2.2.2.5.2 requires 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</p>	K 0222	<p>All affected doors were fitted with the appropriate signage to operate according to guideline and exit door next to 201 was adjusted to meet standard of operating 15 seconds after pushing. All doors were assessed to identify any others that did not meet expectations. Maintenance department educated on K 222 Facility to monitor doors 1 X per</p>	04/04/2018
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	<p>such doors at all times. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/05/18 between 12:04 p.m. and 4:41 p.m., all exit doors were held in the locked position with a magnetic hold down device. Furthermore, the exit door was equipped with an electronic keypad entry system that allowed staff to open the locked exit doors with a combination. A code was posted at each exit door but would not unlock the doors. Based on an interview at the time of observation, the Maintenance Supervisor confirmed the code to unlock the doors was not posted.</p> <p>3.1-19(b)</p> <p>2. The facility failed to ensure the delayed egress locking arrangements were installed in accordance with 7.2.1.6.1(3) in 1 of 3 200 Hall delayed egress locks. LSC 7.2.1.6.1(3) states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions:</p> <p>(a) The force shall not be required to exceed 15 lbf (67 N).</p> <p>(b) The force shall not be required to be continuously applied for more than 3 seconds.</p> <p>(c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening.</p> <p>(d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This</p>		<p>week for 4 weeks, 1 X per month for 3 months, then quarterly until facility is 95% substantial compliant.</p> <p>All negative findings will be reviewed in Monthly QAPI meeting</p>	

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K 0372 SS=F Bldg. 02	<p>deficient practice could affect staff and up to 11 residents.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Supervisor on 03/05/18 at 4:19 p.m., the exit door next to resident room 206 contained a sign indicating to hold for 15 seconds. When tested, the magnetic control failed to release after 15 seconds but did release closer to 30 seconds. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition and confirmed the door did not release in 15 seconds.</p> <p>3.1-19(b)</p> <p>NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3 of 12 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC</p>	K 0372	All affected areas were addressed prior to date of compliance. All other smoke barrier walls were assessed to ensure standard was met.	04/04/2018

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K 0920 SS=E Bldg. 02	<p>Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 03/05/18 between 3:40 p.m. and 4:12 p.m., the following unsealed penetrations were discovered:</p> <p>a) a three quarter inch penetration around conduit in the Therapy smoke barrier above the drop ceiling</p> <p>b) a half inch penetration around wires in the resident room 226 smoke barrier above the drop ceiling. Additionally, a one inch gap around HVAC.</p> <p>c) a three quarter inch penetration around wires in the resident 209 smoke barrier above the drop ceiling</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>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) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in</p>		<p>Maintenance department were educated on K 372</p> <p>The affected areas will be monitored 1 X per week for 4 weeks, 1 X per month for 3 months, then quarterly until facility is 95% substantial compliant. Any negative findings will be addressed in monthly QAPI meeting.</p>	

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	<p>the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 5 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/05/18 at 4:18 p.m., a surge protector was powering another surge protector powering person equipment in resident room 206. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition and confirmed the device was improperly installed.</p>	K 0920	<p>All mentioned areas were addressed to meet standard prior to date of compliance. Facility was searched to identify any other areas not mentioned in survey process. The SDC provided education to staff related to K 920 prior to date of compliance. The affected areas will be monitored 1 X per week for 4 weeks, 1 X per month for 3 months, then quarterly until facility is 95% substantial compliant. All negative findings will be addressed in Monthly QAPI meeting.</p>	04/04/2018
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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