

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2017
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/18/17</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 483.70(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 Type V (111) construction and was fully</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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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 that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0131 SS=E Bldg. 01	<p>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 152 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 01/24/17 - DA</p> <p>NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: * They are not intended to serve four or more inpatients. * They are separated from areas of health care occupancies by construction having a minimum 2-hour fire resistance rating in accordance with Chapter 8. * The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623</p>			

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	<p>Based on observation and interview, the facility failed to ensure the penetration in 2 of 3 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, <i>Standard Test Method for Fire Tests of Through Penetration Fire Stops</i>, or ANSI/UL 1479, <i>Standard for Fire Tests of Through-Penetration Fire Stops</i>. This deficient practice could affect staff and at least 119 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Executive Director and the Maintenance Director on 01/18/17 between 1:06 p.m. and 1:23 p.m., the following fire barriers had unsealed penetrations above the drop</p>	K 0131	<p>The mentioned areas penetrations were sealed by the maintenance department prior to date of compliance.</p> <p>All other Fire barrier doors were reviewed prior to date of compliance to ensure all pass throughs were sealed.</p> <p>Maintenance department reviewed K tag 131</p> <p>The mentioned areas will be reviewed 1 X per week for 4 weeks. 1 X per month for 3 months and then quarterly until 100% compliance is achieved.</p> <p>All negative findings will be reviewed in monthly QUAPI meeting.</p>	02/17/2017	

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K 0222 SS=E Bldg. 01	<p>ceiling:</p> <p>a) a seven inch by three and a half inch piece of drywall were missing on both sides of the Therapy fire barrier</p> <p>b) three separate quarter inch penetrations around wires in the Front Entrance fire barrier</p> <p>c) a quarter inch penetration around wires in the Activity fire barrier</p> <p>d) two separate quarter inch penetrations inside conduit in the resident room 133 fire barrier.</p> <p>Based on interview at the time of each observation, the Executive Director and the Maintenance Director acknowledged each aforementioned condition and provided the measurements.</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</p>			

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	<p>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>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> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p> <p>DELAYED-EGRESS LOCKING ARRANGEMENTS</p> <p>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</p> <p>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</p> <p>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</p> <p>ELEVATOR LOBBY EXIT ACCESS</p>			

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	<p>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 1. Based on observation, record review, and interview, the facility failed to ensure 1 of 4 2nd floor exits, 2 of 4 1st floor exits had a code posted in accordance with 19.2.2.2.5.1. LSC 19.2.2.2.5.1 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 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 staff and up to 10 residents.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Director on 01/18/17 between 10:18 a.m. and 12:56 p.m., the following was discovered: a) the exit/entrance door near the front</p>	K 0222	<p>All mentioned exit areas had a sign posted with the code or a combination identifying what the code would be.</p> <p>All other doors were reviewed to ensure the right codes were next to the key pad or had identifying information on exit procedures.</p> <p>Maintenance department reviewed K tag 222</p> <p>The mentioned areas will be reviewed 1 X per week for 4 weeks. 1 X per month for 3 months and then quarterly until 100% compliance is achieved.</p> <p>All negative findings will be reviewed in monthly QUAPI meeting.</p>	02/17/2017
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	<p>entrance contained a magnetic lock with a keypad. No code was posted.</p> <p>b) the Multipurpose room entrance/exit doors contained a magnetic lock with a keypad. No code was posted.</p> <p>Additionally, a chained door lock was installed on the door would prevent the door from opening if secured.</p> <p>c) the Ambulance entrance/exit door contained a magnetic lock with a keypad. The code posted stated "Use Building Address As Exit Code."</p> <p>Based on an interview at the time of each observation, the Executive Director and the Maintenance Director acknowledged each aforementioned condition and confirmed that residents did not have a special need for the additional security measures.</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 1 delayed egress locks on the first floor by room 109 was readily accessible for residents, staff, and visitors. LSC 7.2.1.6.1, Delayed Egress Locking Systems, says approved, listed, delayed-egress locking systems shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire</p>			

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K 0226	<p>detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided: (4*) A readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This deficient practice could affect staff and up to 5 residents in Activities.</p> <p>Findings include:</p> <p>Based on observation with Executive Director and the Maintenance Director on 01/18/16 at 11:03 a.m., the Activities exit door did not have a sign on the door. Based on interview at the time of observation, the Maintenance Director stated and performed a 15 second test that released the door and acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>			

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SS=E Bldg. 01	<p>Horizontal Exits Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 Based on observation and interview, the facility failed to ensure 3 of 12 fire door sets were arranged to automatically close and latch. LSC 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition NFPA 80 6.1.4.3.1 states the fire door shall latch upon closing. This deficient could affect 78 residents.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Director on 01/18/17 between 10:28 a.m. then again at 12:36 p.m., the following fire barriers failed to latch: a) fire barrier near resident room 128 failed to latch b) fire barrier near resident room 118 failed to latch c) fire barrier near resident room 231 failed to latch Based on interview at the time of each observation, Executive Director and the Maintenance Director confirmed site plans indicated the cross corridor doors were fire barrier doors and had 90 minute</p>	K 0226	<p>All mentioned fire doors were adjusted by maintenance department to ensure they latch. This was completed prior to date of compliance.</p> <p>All other Fire Doors were reviewed prior to date of compliance to ensure they would appropriate latch.</p> <p>Maintenance department reviewed K tag 226</p> <p>The mentioned areas will be reviewed 1 X per week for 4 weeks. 1 X per month for 3 months and then quarterly until 100% compliance is achieved.</p> <p>All negative findings will be reviewed in monthly QUAPI meeting.</p>	02/17/2017

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K 0232 SS=E Bldg. 01	<p>fire resistive labels.</p> <p>3.1-19(b)</p> <p>NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to maintain 1 of 2 200 Hall corridors from obstructions per 19.2.3.4. LSC 19.2.3.4.5 requires aisles, corridors, and ramps to be arranged to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers. This deficient practice could affect staff and up to 6 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/18/17 at 12:55 p.m., a bed, empty isolation cart, and a 32 gallon soiled linen container were in the corridor outside resident room 204. Based on interview at the time of observation, the Maintenance Director was unaware of items in the corridor and</p>	K 0232	<p>232 bed isolation cart and 32 gallon soiled linen container</p> <p>Facility removed the bed, isolation cart and 32 gallon linen container prior to survey exit.</p> <p>Facility reviewed all areas to ensure that they were free of hazards prior to date of compliance.</p> <p>Maintenance department reviewed K tag 232</p> <p>The mentioned areas will be reviewed 1 X per week for 4 weeks. 1 X per month for 3 months and then quarterly until 100% compliance is achieved.</p> <p>All negative findings will be reviewed in monthly QUAPI meeting.</p>	02/17/2017
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K 0271 SS=E Bldg. 01	<p>no one was in the area for the soiled linen container.</p> <p>3.1-19(b)</p> <p>NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. 18.2.7, 19.2.7, S&C 05-38</p> <p>Based on observation and interview, the facility failed to ensure exit discharge to a public way was provided for 1 of 5 100 Hall exits in accordance with 19.2.7. LSC Section 19.2.7 requires discharge from exits shall be arranged in accordance with Section 7.7. LSC Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. In addition to providing the required width to allow all occupants safe access to a public way, such access also needs to meet the requirements with respect to maintaining</p>	K 0271	<p>Facility working to get all estimates for new sidewalk that leads to a parking lot by 2.28.17. Facility will use an outside contractor for this work.</p> <p>Facility walked thru grounds and did not identify any other pathways that violated K 271.</p> <p>Maintenance department educated on K 271</p> <p>Facility to have the work to be completed by 4.21.17</p>	05/05/2017

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K 0321 SS=D Bldg. 01	<p>the means of egress free of obstructions that would prevent its use, such as snow and the need for its removal in some climates or soft ground during heavy periods of rain. This deficient practice could affect staff and at least 8 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/18/17 at 10:49 a.m. the exit discharge path next to resident room 108 goes back into the 300 Hall lounge. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed that the exits do not lead to a public way.</p> <p>3.1-19(b)</p> <p>NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or</p>			

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	<p>field-applied protective plates that do not exceed 48 inches from the bottom of the door.</p> <p>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.</p> <p>19.3.2.1</p> <p>Area Automatic Sprinkler Seperation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220)</p> <p>Based on observation and interview, the facility failed to maintain protection of 1 of 1 Laundry room in accordance of 19.3.2. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Director on 01/18/17 at 12:21 p.m., the Laundry room contained fuel-fire equipment and was greater than 100 square feet. One of two sets of Laundry room corridor doors failed to latch when tested. Both sets of corridor doors contained an astragal and</p>	K 0321	<p>321 Laundry room doors</p> <p>Laundry room doors were adjusted to latch correctly and 301 was adjusted to storage room standards, by the maintenance department, prior to date of compliance.</p> <p>All other doors were reviewed to ensure latching occurred correctly, by the maintenance department, prior to date of compliance.</p> <p>Maintenance department reviewed K tag 321</p> <p>The mentioned areas will be reviewed 1 X per week for 4 weeks. 1 X per month for 3 months and then quarterly until 100%</p>	02/17/2017

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K 0353 SS=F Bldg. 01	<p>no coordinating device. Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged the aforementioned condition.</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. 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>1. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire</p>	K 0353	<p>compliance is achieved.</p> <p>All negative findings will be reviewed in monthly QUAPI meeting.</p> <p>353 sprinkler system</p> <p>Facility had sprinkler system inspected prior to date of compliance. Facility replaced escutcheon near resident room 228 prior to date of compliance.</p> <p>Facility developed a plan to have</p>	02/17/2017

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	<p>Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Executive Director and the Maintenance Director on 01/18/17 at 9:47 a.m., the sprinkler system was inspected quarterly. No documentation was available for the monthly gauges or control valves inspection. Based on interview at the time of record review, the Executive Director and the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 2 200 Hall corridors. 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</p>		<p>sprinkler system reviewed monthly, and inspected all other escutcheons prior to date of compliance.</p> <p>Maintenance department reviewed K tag 353</p> <p>The mentioned areas will be reviewed 1 X per week for 4 weeks. 1 X per month for 3 months and then quarterly until 100% compliance is achieved.</p> <p>All negative findings will be reviewed in monthly QUAPI meeting.</p>	

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K 0363 SS=D Bldg. 01	<p>and up to 11 residents.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Director on 01/18/17 at 12:39 p.m., in the corridor near resident room 228 was missing an escutcheon. Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>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</p>			

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	<p>materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted.</p> <p>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 ensure 1 of 1 Dietary Office corridor doors had no impediment to closing and positively latched into the frame. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Director on 01/18/17 at 12:12 p.m., the Dietary Office corridor door contained a door stop holding the door open. Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged the aforementioned condition.</p>	K 0363	<p>363 Dietary office door stop</p> <p>Facility removed the door stop prior to date of compliance.</p> <p>Facility checked all other office doors to ensure they had no impediments that would stop the door from closing.</p> <p>Maintenance department reviewed K tag 363</p> <p>The mentioned area will be reviewed 1 X per week for 4 weeks. 1 X per month for 3 months and then quarterly until 100% compliance is achieved.</p> <p>All negative findings will be reviewed in monthly QUAPI meeting.</p>	02/17/2017	

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K 0511 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure electrical outlets were protected in 1 of 1 Main Dining Room Alcove and 1 of 1 Kitchen according to 19.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could staff and up to 119 residents in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/18/17 at 12:08 p.m. then again at 12:13 p.m., one of the outlets in the Main Dining Room Alcove was missing an outlet cover. Then again, one of the outlets in the Kitchen was missing an outlet cover.</p>	K 0511	<p>511 Outlet Covers</p> <p>Facility replaced missing outlet covers that were mentioned in the 2567, prior to date of compliance.</p> <p>Maintenance department reviewed all other outlets to identify any unusual findings, prior to date of compliance.</p> <p>Maintenance department reviewed K tag 511</p> <p>The mentioned area will be reviewed 1 X per week for 4 weeks. 1 X per month for 3 months and then quarterly until 100% compliance is achieved.</p> <p>All negative findings will be reviewed in monthly QUAPI meeting.</p>	02/17/2017

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K 0521 Bldg. 01	<p>Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2</p> <p>Based on record review, observation and interview; the facility failed to ensure 8 of 72 fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall be</p>	K 0521	<p>521 Fire Damper test</p> <p>Facility ordered fire dampers prior to date of compliance. Facility had electrician and Damper Inspection Company come together on 2.7.16. Fire dampers take a few weeks to come in once ordered. Facility expects to have dampers completed prior to March 10th.</p> <p>Maintenance department reviewed all other inspection reports for dampers to insure we were in compliance.</p> <p>Maintenance department reviewed K tag 521</p> <p>The mentioned area will be reviewed 1 X per week for 4 weeks. 1 X per month for 3 months and</p>	03/10/2017

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	<p>every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect staff and at least 65 residents.</p> <p>Findings include:</p> <p>Based on record review with the Executive Director and the Maintenance Director on 01/18/17 between 9:10 a.m. and 10:15 a.m., the "Alarm and Detection Equipment Test Report" by VFP Fire Systems performed on 04/23/13 indicated eight fire dampers failed the test. Based on interview at the time of record review, the Executive Director and the Maintenance Director provided a proposal contract but no other documentation indicating work was completed and the eight dampers passed inspection.</p>		<p>then quarterly until 100% compliance is achieved.</p> <p>All negative findings will be reviewed in monthly QUAPI meeting.</p>		

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K 0711 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3</p> <p>Based on record review and interview, the facility failed to provide a 1 of 1 written fire plans at the 100 Hall Nurses' Station in accordance with 19.7.1.3. This deficient practice could affect staff and at least 54 residents.</p> <p>Findings include:</p> <p>Based on a record review and interview on 01/18/17 at 10:57 a.m., the Executive Director and the Maintenance Director acknowledged no documentation for a written fire safety plan at the 100 Hall Nurses' station was available for review.</p> <p>3.1-19(b)</p>	K 0711	<p>711 Fire safety plan ACU</p> <p>Facility had fire safety plan placed on 100 hall prior to date of compliance.</p> <p>Maintenance department reviewed all other halls to ensure that safety plans were in place.</p> <p>Maintenance department reviewed K tag 711</p> <p>The mentioned area will be reviewed 1 X per week for 4 weeks. 1 X per month for 3 months and then quarterly until 100% compliance is achieved.</p> <p>All negative findings will be reviewed in monthly QUAPI meeting.</p>	02/17/2017

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K 0712 SS=C Bldg. 01	<p>NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all staff and residents.</p> <p>Findings include:</p> <p>Based on record review of the "Report of Monthly Fire Drill" form with the Executive Director and the Maintenance Director on 01/18/17 at 9:37 a.m., four sequential second shift fire drills took place between 3:00 p.m. and 4:00 p.m. for four of the last four quarters. Based on interview at the time of record review, the Executive Director and the Maintenance Director acknowledged the aforementioned condition.</p>	K 0712	<p>712 Fire Drills</p> <p>Facility did a days shift, monthly fire drill, prior to date of compliance.</p> <p>Facility will alternate fire drills to meet the K 712 expectation.</p> <p>Maintenance department reviewed K tag 712</p> <p>All negative findings will be reviewed in monthly QUAPI meeting.</p>	02/17/2017			

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K 0753 SS=E Bldg. 01	<p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: * Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. * Decorations meet NFPA 701. * Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. * Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6 or 19.7.5.6. * The decorations in existing occupancies are in such limited quantities that a hazard of fire is not present. 18.7.5.6, 19.7.5.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 105 resident rooms was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect staff and up to 11 residents.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Maintenance Director on 01/18/17 at 12:38 p.m., resident room 230 contained one candle with a wick.</p>	K 0753	<p>753 candle in room</p> <p>Facility removed candle from resident room immediately.</p> <p>Facility audited all rooms to ensure that no combustible decorations.</p> <p>Maintenance department along with department heads were educated on K tag 753.</p> <p>Facility will audit for combustible decorations 1 X per week for 4 weeks, 1 X per month for 3 months and then quarterly until 95% compliance is achieved.</p>	02/17/2017

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K 0920 SS=E Bldg. 01	<p>Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged the aforementioned condition.</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 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 3 of 3 flexible cords were not used as a substitute for</p>	K 0920	<p>All negative findings will be reviewed in monthly QUAPI meeting.</p> <p>920 Power cords and surge protectors.</p> <p>All extension cords and surge</p>	02/17/2017	

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	<p>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 119 residents in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Director on 01/18/17 between 10:59 a.m. and 12:06 p.m., the following was discovered:</p> <ul style="list-style-type: none"> a) an extension cord was powering a computer in the MDS office b) a surge protector was powering a coffee pot in the Memory Care Director office c) a surge protector was powering a microwave in the Medical Records office d) an extension cord was run into the drop ceiling in the Main Dining Room. <p>Based on interview at the time of each observation, the Executive Director and the Maintenance Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p>protectors were removed from the affected area.</p> <p>Facility audited all areas to ensure that there were no other extension cords or surge protectors being utilized.</p> <p>Maintenance department and department heads reviewed K tag 711</p> <p>The mentioned area will be reviewed 1 X per week for 4 weeks. 1 X per month for 3 months and then quarterly until 100% compliance is achieved.</p> <p>All negative findings will be reviewed in monthly QUAPI meeting.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2017
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368
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K 0927 SS=E Bldg. 01	<p>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)</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 100 Hall oxygen transfill room was protected in accordance with 9.3.7.5.3.1. 2012 NFPA 99 9.3.7.5.3.1 requires oxygen transfill mechanical exhaust rooms to maintain a negative pressure continuously. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Director on 01/18/17 at 10:35 a.m., the 400 Hall oxygen transfill room fan was not running. The fan was checked with a piece of paper. Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged the aforementioned</p>	K 0927	<p>927 free standing cylinders, exhaust system, O2 room</p> <p>Facility placed racks in the oxygen room for free standing cylinders, the exhaust fan had the motor replaced and the oxygen room had a cylinder taken out and shelving adjusted for optimal function. This was completed by date of compliance.</p> <p>All other oxygen rooms were audited for free standing oxygen, ample space and exhaust fans functioning appropriately.</p> <p>Maintenance department and department heads were educated on K tag 927.</p> <p>The mentioned area will be reviewed 1 X per week for 4 weeks. 1 X per month for 3 months and then quarterly until 100% compliance is achieved.</p>	02/17/2017

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	<p>condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to protect oxygen cylinders in the 1 of 1 100 Hall and 1 of 1 200 Wing oxygen transfill rooms. 2012 NFPA 99, Health Care Facilities Code, 11.6.2.3(11) requires freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Director on 01/18/17 at 10:35 a.m. then again at 12:57 p.m., 100 Hall transfill room had two oxygen cylinders that were freestanding on the floor. Then again, 200 Hall transfill room had one oxygen cylinder that was freestanding on the floor. Based on interview at the time of each observation, the Executive Director and the Maintenance Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p>All negative findings will be reviewed in monthly QUAPI meeting.</p>	

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K 0000 Bldg. 02	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/18/17</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 483.70(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</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 0271 SS=E Bldg. 02	<p>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 152 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 01/24/17 - DA</p> <p>NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. 18.2.7, 19.2.7, S&C 05-38</p> <p>Based on observation and interview, the facility failed to ensure exit discharge to a public way was provided for 1 of 4 300 Hall exits in accordance with 19.2.7. LSC Section 19.2.7 requires discharge from exits shall be arranged in accordance with Section 7.7. LSC Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts,</p>	K 0271	<p>Facility working to get all estimates for new sidewalk that leads to a parking lot by 2.28.17. Facility will use an outside contractor for this work.</p> <p>Facility walked thru grounds and did not identify any other pathways that violated K 271.</p> <p>Maintenance department educated on K 271</p> <p>Facility to have the work to be</p>	05/05/2017

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K 0321	<p>open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. In addition to providing the required width to allow all occupants safe access to a public way, such access also needs to meet the requirements with respect to maintaining the means of egress free of obstructions that would prevent its use, such as snow and the need for its removal in some climates or soft ground during heavy periods of rain. This deficient practice could affect staff and at least 11 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/18/17 between 10:15 a.m. and 1:50 p.m., the exit discharge path from the 300 Hall lounge and the exit discharge path next to resident room 314 goes back into the 100 Hall near resident room 108. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition and confirmed that the exits do not lead to a public way.</p> <p>3.1-19(b) NFPA 101</p>		completed by 4.21.17	

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SS=E Bldg. 02	<p>Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1</p> <p>Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220)</p> <p>Based on observation and interview, the facility failed to maintain protection of 1 of 1 Storage room 301 greater than 50 square feet in accordance of 19.3.2. LSC 19.3.2.1.3 requires doors to be</p>	K 0321	<p>321 Laundry room doors</p> <p>Laundry room doors were adjusted to latch correctly and 301 was adjusted to storage room standards, by the maintenance department, prior to date of compliance.</p>	02/17/2017			

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K 0927 SS=E Bldg. 02	<p>self-closing or automatic closing. This deficient practice could affect staff and up to 119 residents in the Main Dining room.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Director on 01/18/17 at 11:17 a.m., resident room 301 was being used as storage. Inside the room was at least nine mattress and five bed frames. Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged the corridor door did not have a self-closing or automatic closing device installed.</p> <p>3.1-19(b)</p> <p>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).</p>		<p>All other doors were reviewed to ensure latching occurred correctly, by the maintenance department, prior to date of compliance.</p> <p>Maintenance department reviewed K tag 321</p> <p>The mentioned areas will be reviewed 1 X per week for 4 weeks. 1 X per month for 3 months and then quarterly until 100% compliance is achieved.</p> <p>All negative findings will be reviewed in monthly QUAPI meeting.</p>				

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	<p>11.5.2.2 (NFPA 99)</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 300 Hall transfill room used for transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire-resistive construction. This deficient practice could affect staff and at least 7 residents.</p> <p>Findings include:</p> <p>Based on an observation at the time of interview with the Executive Director and the Maintenance Director on 01/18/17 at 11:55 a.m., the Licensed Practical Nurse was asked to simulate transfilling oxygen in the 300 Hall transfill room. During the simulation, she propped the door open with her foot. Based on interview at the time of observation, she confirmed that the room is not big enough to transfill inside the room and if she did, she gets claustrophobic.</p> <p>3.1-19(b)</p>	K 0927	<p>927 free standing cylinders, exhaust system, O2 room</p> <p>Facility placed racks in the oxygen room for free standing cylinders, the exhaust fan had the motor replaced and the oxygen room had a cylinder taken out and shelving adjusted for optimal function. This was completed by date of compliance.</p> <p>All other oxygen rooms were audited for free standing oxygen, ample space and exhaust fans functioning appropriately.</p> <p>Maintenance department and department heads were educated on K tag 927.</p> <p>The mentioned area will be reviewed 1 X per week for 4 weeks. 1 X per month for 3 months and then quarterly until 100% compliance is achieved.</p> <p>All negative findings will be reviewed in monthly QUAPI meeting.</p>	02/17/2017			