STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155277	A. BUILDING 01 B. WING	07/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE VALPARAISO	3301 N CALUMET AVE VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/12-13/16 Facility Number: 000176 Provider Number: 155277 AIM Number: 100288940 At this Life Safety Code survey, Aperion Care Valparaiso was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility is located in two, two story buildings with walk out lower levels and connected by the "tunnel", a one story corridor. The two buildings, identified as the Pines and the Manor were determined to be of Type II (111) construction, built prior to March 1, 2003 and fully sprinklered. The facility has a fire alarm system with smoke detection in the	K 0000		

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

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	corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in resident sleeping Rooms #1 through #37 on the Pines upper level and hard wired smoke detectors supervised by the fire alarm system in rooms 38 through 43 on the Pines lower level. Smoke detectors in resident sleeping rooms on the upper and lower level are hard wired. The facility has the capacity for 150 and had a census of 85 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 07/19/16 - DA			
K 0018 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD 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 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall			

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	be provided with a means suitable for keeping the door closed. 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 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 1. Based on observation and interview, the facility failed to ensure 1 of 1 Maple Unit nurses' station medication room corridor door did not have an impediment to latching. This deficient practice could affect staff and up to 25 residents. Findings include: Based on observation and interview on 07/12/16 at 3:35 p.m., the Maintenance Director acknowledged the corridor door to the Maple Unit Nurses' station medication room had a door stop that prevented the corridor door from closing and latching into the door frame. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 73 resident room corridor doors closed and positively latched into the door frame. This deficient practice could affect staff and up to 2 residents. Findings include:	K 0018	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1. Immediate actions taken for those residents identified:** No residents were identified in this citation.	08/12/2016

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	Based on observation with the Maintenance Director on 07/12/16 at 12:22 p.m., resident room 174 corridor door failed to latch into the frame when tested. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition. 3.1-19(b)		**2. How the facility identified other residents:** All residents on the Maple unit have the potential to be affected by this alleged deficient practice. **3. Measures put into place/ System changes:** The door stop on the Maples nurse's station medication room was immediately removed. The latch assembly for resident room 174 was adjusted and tested to latch. Staff were in-serviced on not using door stops to prop doors open. Resident doors will be tested randomly on all units at a minimum of 10 doors per week for proper latching when closed and for any door stops in use. The Director of Plant Operations/designee will oversee these audits and report findings to the QAA committee. **4. How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months.	

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K 0020 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 Based on observation and interview, the facility failed to ensure 1 of 3 vertical opening stairways was enclosed with construction having a fire resistance rating of at least one hour. This deficient practice could affect staff only because the resident wing is not in use. Findings include: Based on observation with the Maintenance Director on 07/12/16 at 1:00 p.m., the Pine South stairwell had a one inch hole unsealed in the wall. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and provided the measurement. 3.1-19(b)	K 0020	**5. Date of compliance: 8/12/2016** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for**	08/12/2016

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			those residents identified: No residents were identified in this citation. **2) How the facility identified other residents:** The Pines South unit is currently not in use for residents so no other residents would be affected. **3) Measures put into place/ System changes:** Maintenance repaired the 1" hole in the stairwell with fire rated caulk. Director of Plant Operations/designee will continue to observe all fire wall areas for any breaches in barrier, an additional inspection will be conducted by the Director of Plant Operations/designee after any contractor/construction repairs are made in the facility. Any findings of firewall breaches will be corrected and reported to the Administrator and QAA committee. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance	

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			Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance: 8/12/2016**	
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the facility failed to ensure 1 of 8 corridors, 1 of 1 ceiling smoke barriers and 1 of 3 smoke barrier walls were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect staff and at least 28 residents. Findings include: Based on observations with the Maintenance Director on 07/12/16 from 11:55 a.m. to 1:45 p.m., the following	K 0025	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or*	08/12/2016

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	corridor wall, smoke barrier wall, and ceiling penetrations were unsealed: a. a four inch by two inch corridor penetrations in the Rehabilitation hall nurses' station b. a one and a half inch ceiling penetration in the Rehabilitation hall utility closet c. two out of forty ceiling tiles were missing in the Pines Lower hall storage room across from laundry d. a four inch ceiling penetration in the Rehabilitation hall near exit door #3 e. two out of thirty ceiling tiles were missing in the Pines Lower hall IT room f. a two inch and an eight inch ceiling penetration in the Pines elevator room Based on observations with the Maintenance Director on 07/13/16 at 11:50 a.m. then again at 11:11 a.m., the Manor Lower smoke barrier had a two in a half inch gap inside conduit above the drop ceiling. Then again, a four inch by two inch ceiling penetration in the Pines Upper storage room. Based on interview at the time of each observation, the Maintenance Director acknowledged and provided the measurements for each unsealed penetration. 3.1-19(b)		*executed solely because it is required by the provisions of federal and state law.* **1. Immediate actions taken for those residents identified:** No residents were identified in this citation. **2. How the facility identified other residents:** All residents in the areas of these alleged deficiencies have the potential to be affected. **3. Measures put into place/ System changes:** The corridor penetration in the Rehabilitation Nurses station was repaired. The ceiling penetration in the rehabilitation hall utility closet was repaired. The missing ceiling tiles in the Pines Lower storage room were replaced. The ceiling tile near exit door #3 on the rehabilitation unit was replaced. The missing ceiling tiles in the Pines	

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			Lower IT room were replaced. The ceiling penetration in the Pines elevator room was repaired. The conduit above the drop ceiling on Manor Lower was repaired with fire retardant caulk. The smoke barrier in the Pines Upper storage room, the ceiling tile was replaced. An inspection of the complete facility was conducted by the surveyor and the Maintenance director and no other areas of non-compliance were noted. The Director of Plant Operations/designee will inspect any areas that contractors have worked in for any areas of non-compliance. Any areas noted will be corrected and reported to the Administrator and QAA committee. **4. How the corrective actions will be monitored:** The results of these findings will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months. **5. Date of compliance:**	

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			8/12/2016	
K 0027 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 3 sets of smoke barrier doors would close to form a smoke resistant barrier. This deficient practice could affect staff and up to 18 residents. Findings include: Based on observation with the Maintenance Director on 07/12/16 at 12:01 p.m., the Rehabilitation smoke barrier doors near the Dining Room failed to close when tested. Both doors got caught up on the coordinating device. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.	K 0027	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	08/12/2016

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	3.1-19(b)		**1) Immediate actions taken for those residents identified:** No residents were identified in this citation. **2) How the facility identified other residents:** Any residents on the Rehabilitation have the potential to be affected by this alleged deficient practice. **3) Measures put into place/ System changes:** The coordinator for the smoke barrier doors near the dining room on the Rehabilitation unit was adjusted to allow for proper closing of doors when released. The Director of Plant Operations/designee will continue to monitor doors for proper closing during all regular fire drills. Any doors found in non-compliance will be reported to the Administrator/QAA committee along with completed corrective action taken. **4) How the corrective actions will**	

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			be monitored: The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance: 8/12/2016**	
K 0029 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 1. Based on observation and interview, the facility failed to ensure 1 of 1 fuel fired Hazardous Storage/ Mechanical room and 1 of 1 fuel fired Manor Boiler room, hazardous areas, was provided with self-closer and would latch into the frame. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Director on 07/12/16 at	K 0029	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the*	08/12/2016

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	1:18 p.m. then again at 2:55 p.m., the Hazardous Storage/Mechanical room corridor door got caught up on the door frame and failed to latch when tested. Then again, the Manor Boiler room contained a set of double doors without a coordinating device. One of the double doors had two slide bolts and no self-closing device. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 Maintenance storage room greater than 50 square feet, hazardous areas, would latch into the frame. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Director on 07/12/16 at 1:30 p.m., the Maintenance storage room corridor door failed to latch when tested. The room contained at least twenty large cardboard boxes, clean linen storage, and an approved flammable liquids storage cabinet, and other miscellaneous storage. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned		*provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** No residents were identified in this citation. **2) How the facility identified other residents:** These areas were not in resident common areas and would have the potential to affect staff only. **3) Measures put into place/ System changes:** The Hazardous Storage/Mechanical room door was installed with a self-closer. The door was adjusted to latch properly. The Manor Boiler room double doors have had the slide bolts removed, a self-closing device installed and a coordinating closure device installed, doors were tested for compliance.	

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	condition. 3.1-19(b)		The Maintenance storage room corridor door was adjusted to latch properly. The Director of Plant Operations/designee will continue to monitor doors for proper closing during all regular fire drills. Any doors found in non-compliance will be reported to the Administrator/QAA committee along with completed corrective action taken. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance: 8/12/2016**	
K 0048 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written plan that addressed all components in 1	K 0048	**The facility requests paper compliance for this citation.**	08/12/2016

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	of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect staff and up to 8 residents. Findings include: Based on a record review with the Maintenance Director on 07/14/16 between 11:15 a.m. and 3:45 p.m., the facility had a written fire policy that horizontal evacuation would be performed by horizontal and vertical evacuation. However, there were corridor doors that were not complete smoke or fire barriers which could cause staff to evacuate residents to a different part of the same smoke compartment and not to an adjacent compartment in the event of a fire. Based on observation, the set of doors near resident room 174 and resident room 23 were not complete		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** No residents were identified in this citation. **2) How the facility identified other residents:** Any residents in the area of resident rooms 174 and 23 have the potential to be affected by this alleged deficient practice.	

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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
	smoke barriers because the hourly fire protection did not extend from exterior wall to exterior wall. Based on interview at the time of each observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)		**3) Measures put into place/ System changes:** The double doors near resident room 174 were removed from area. The double doors near room 23 remain in place to separate a temporarily closed area from the general population. Signage has been posted to alert visitors, family, staff that these doors do not provide a barrier in case of fire. Staff has been in-serviced on the purpose of the double doors near room 23, procedures to follow during a fire/ fire drill and where to evacuate to from this area in event of a fire. The Director of Plant Operations/designee will monitor any new construction/remodel involving fire/smoke barrier doors to ensure compliance. Any concerns of non-compliance will be reported to the Administrator. **4) How the corrective actions will be monitored:** The results of any non-compliance concerns from audits will be reviewed by the Quality Assurance Committee.	

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			5) Date of compliance: 8/12/2016	
K 0056 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 2 sprinklers in room 21 was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Table 5-6.5.1.2 states that distance between a sprinkler head and an obstruction less than 1 foot away cannot be lower than the sprinkler head deflector. This deficient practice could affect staff and at least 6 residents. Findings include:	K 0056	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state*	08/12/2016

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	Based on observation with the Maintenance Director on 07/13/16 at 10:17 a.m., the spray pattern for a sprinkler head in room 21 was located next to a ceiling box light. Measurements showed the sprinkler head was 3 inches away from the ceiling light. The ceiling light was measured to be 2 inches lower than the sprinkler head deflector. Based on interview at the time of observation, the Maintenance Director acknowledged the abovementioned condition and provided the measurements. 3.1-19(b)		*law.* **1) Immediate actions taken for those residents identified:** No residents were identified in this citation. **2) How the facility identified other residents:** Any resident residing in room 21 has the potential to be affected by this alleged deficient practice. **3) Measures put into place/ System changes:** The light fixture in room 21 was relocated for compliance. An inspection was completed of all rooms in this facility by the maintenance director and the surveyors and no other areas of non-compliance were noted. The Director of Plant Operations/designee will inspect any areas of contractor work involving light fixtures for compliance. Any concerns of non-compliance will be reported to the Administrator/ QAA committee along with corrective action taken.	

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			4) How the corrective actions will be monitored: The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance: 8/12/2016**	
K 0062 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on record review, interview and observation, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one	K 0062	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the*	08/12/2016

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	that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on record review with the Maintenance Director on 07/12/16 at 11:10 a.m., none of the quarterly sprinkler system inspection and testing records indicated an internal inspection of the sprinkler system pipes had been conducted. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition and confirmed the sprinkler system is over five years old. Based on observation, the sprinkler riser indicated the last internal inspection was performed on 11/09/10. 3.1-19(b) 2. Based on observation and interview, the facility failed to replace 1 of 1 painted sprinkler head in the Upper Manor foyer. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and		*provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** No residents were identified in this citation. **2) How the facility identified other residents:** This alleged deficient practice could affect residents located near the Pines upper dining room and the Manor upper foyer. **3) Measures put into place/ System changes:** Vendor has been scheduled to complete an internal sprinkler pipe inspection. Vendor has been scheduled to replace the sprinkler head in the Manor upper level foyer. Vendor has been schedule to replace the escutcheon in the Pines upper	

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	maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff and up to 12 residents. Findings include: Based on observation with the Maintenance Director on 07/12/16 at 3:20 p.m., one sprinkler head was covered in paint in the Upper Manor foyer. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 15 sprinkler heads in Pine Upper Dining room was maintained. This deficient practice could affect staff and up to 12 residents. Findings include: Based on observations the Maintenance		dining room. The cardboard box was relocated in the Kitchen freezer. An inspection of all sprinkler heads and escutcheons was completed with the maintenance director and the surveyors. No other concerns were noted. Staff were in-serviced on the importance of allowing proper clearance below sprinkler head deflectors, to be observant of sprinkler head condition and placement of escutcheons throughout the facility. Director of Plant Operations/designee will audit a minimum of 5 resident rooms, 2 common areas per week and 2 nonresident areas per week sprinkler head condition, placement of escutcheons and proper clearance provided below sprinkler deflectors. Results of these audits will be reported to the Administrator/designee. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months.	

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	Director on 07/13/16 at 10:37 a.m., one escutcheon was missing in the Pine Upper Dining Room. Based on interview at the time of observation, the Maintenance Director acknowledged the missing escutcheon at the time of each observation. 3.1-19(b) 4. Based on observation and interview, the facility failed to maintain clearance to storage for 1 of 1 sprinkler head in the Kitchen freezer. LSC 9.7.1.1 requires each automatic sprinkler system shall be installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1998 edition, 5-5.6 requires the clearance between the deflector and the top of the storage shall be 18 inches. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Director on 07/12/16 at 3:00 p.m., a large cardboard box was stacked within 10 inches from the sprinkler head deflector. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and provided the measurement.		**5) Date of compliance: 8/12/2016**	

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	3.1-19(b)			
K 0066 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is 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 is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for staff and residents were maintained. This deficient practice could affect staff and up to 2 residents. Findings include: Based on observations with the Maintenance Director on 07/12/16 at	K 0066	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this*	08/12/2016

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	12:11 p.m., there were at least 30 cigarette butts in the trash can with combustible trash inside. Additionally, some cigarette butts were on the ground. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)		*plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** No residents were identified in this citation. **2) How the facility identified other residents:** This smoking area is located in a concrete/stuco surrounded area and is for staff only. No residents would be affected by this alleged deficient practice. **3) Measures put into place/ System changes:** The staff smoking area has been provided with covered metal trash cans and separate smoke pots. Staff have been in-serviced on the designated area for smoking, importance of disposing ashes/butts	

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			and trash in proper containers. Director of Plant Operations/designee will monitor this smoking area for compliance at various times a minimum of 10x per week. Any findings of non-compliance will be reported to the Administrator and QAA committee. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance: 8/12/2016**	
K 0070 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 Based on observation and interview, the facility failed to ensure 1 of 1 space heaters was equipped with a heating element which would not exceed 212	K 0070	**The facility requests paper compliance for this citation.**	08/12/2016

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	degrees Fahrenheit (F). This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Director on 07/12/16 at 2:47 p.m., a space heater was discovered in the Basement Medical Records area. Based on interview at the time of observation, the Maintenance Director was unable to provide documentation to confirm the space heater element did not exceed 212 degrees (100 degrees C). 3.1-19(b)		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** No residents were identified in this citation. **2) How the facility identified other residents:** The basement medical records area is a secured area not accessible to residents. **3) Measures put into place/ System changes:**	

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			The space heater located in the basement area was removed. The management team was in-serviced on facility guideline that any electrical heating appliance must be approved by the Director of Plant Operations/designee before being put into use in this facility. The Plant Operations Director/designee will maintain a log of any electrical heating appliances in operation in the facility. These appliances must meet Life Safety Code requirements before being placed into service. The initial log and any new additions to this log will be presented to the QAA committee for review and recommendations. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months **5) Date of compliance: 8/12/2016**	
K 0076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD			

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Bldg. 01	Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 73 resident rooms was not used to stored liquid oxygen. This deficient practice could affect staff and at least 3 residents. Findings include: Based on observation with the Maintenance Director on 07/12/16 at 10:57 a.m., resident room 1 contained two liquid oxygen container. One container was in use, the other one was stored in the room not in use. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)	K 0076	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The extra oxygen container located	08/12/2016

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			in the resident room 1 was immediately removed and place in oxygen storage area. **2) How the facility identified other residents:** Residents who require liquid oxygen in their rooms have the potential of being affected by this alleged deficient practice. **3) Measures put into place/ System changes:** Extra container was removed from the resident room. Inspection of remaining resident rooms was completed by the maintenance director and the surveyors with no other findings of oxygen storage concerns noted. Nursing staff and Guardian Angels were in-serviced on the importance of returning any Liquid Oxygen storage/fill tanks back to the oxygen storage/fill room immediately after switching out tanks. Guardian Angels will observe rooms during rounds to assure compliance. Results are reviewed during morning meetings for any concerns of noncompliance.	

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			4) How the corrective actions will be monitored: The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months **5) Date of compliance: 8/12/2016**	
K 0130 SS=F Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 1. Based on record review and interview, the facility failed to ensure a battery replacement program was provided to ensure 73 of 73 single station smoke detectors would operate. This deficient practice affects all residents. Findings include: Based on record review with the Maintenance Director on 03/12/16 at 11:00 a.m., the battery replacement paperwork for the seventy three single station smoke detectors in resident rooms did not include when the batteries were replaced. Based on interview at the time of record review, the Maintenance Director acknowledged the	K 0130	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state*	08/12/2016

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	aforementioned condition and confirmed no other documentation is available for review. 3.1-19(b) 2. Based on observation and interview, the facility failed to replace at least 1 of 37 single station smoke detectors older than 10 years. NFPA 72, National Fire Alarm Code, 1999 Edition, 8-3.5 requires that unless otherwise recommended by the manufacturer, smoke alarms shall not remain in service longer than 10 years from the date of installation. This deficient practice affects at least 2 residents. Findings include: Based on observation with the Maintenance Director on 07/12/16 at 11:05 a.m., resident room 09 single station smoke detector indicated it was manufactured on 11/2003. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed no other documentation is available for review. 3.1-19(b)		*law.* **1. Immediate actions taken for those residents identified:** The smoke detector in resident room 9 was replaced with a new detector. **2. How the facility identified other residents:** Residents with expired smoke detectors have the potential to be affected by this alleged deficient practice. **3. Measures put into place/ System changes:** The preventative maintenance log for battery operated smoke detectors was updated to allow for the date batteries are changed and inspection of expiration date of each detector. Batteries will continue to be changed on a semi-annual basis. An audit of all resident room battery operated smoke detectors was completed for any expired units. Any units within 1 year of expiration were replaced. Director of Plant Operations/designee will oversee	

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	3. Based on observation and interview, the facility failed to maintain 1 of 37 single station smoke detectors per manufacturer's recommendation. This deficient practice affects at least 2 residents. Findings include: Based on record review with the Maintenance Director on 07/12/16 at 11:05 a.m., the single station smoke alarms were inspected monthly. Based on observation, at a.m., resident room 09 single station smoke detector indicated the device should be inspected weekly. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed no other documentation is available for review 3.1-19(b)		these audits and report any findings of non-compliance to the Quality Assurance Committee. **4. How the corrective actions will be monitored:** Results of semi-annual audits will be reviewed by the Quality Assurance Committee for compliance on-going or until the QA committee determines compliance. **5. Date of compliance: 8/12/2016**	
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 1. Based on observation and interview, the facility failed to ensure 1 of 1 Old	K 0147	**The facility requests paper compliance for this citation.**	08/12/2016

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	Nurses' office storage, 1 of 1 Rehabilitation lounge bathroom, 1 of 1 Room 159, and 1 of 1 Upper Manor-Linden clean utility room electrical receptacles was provided with a ground fault circuit interrupter (GFCI) protection against electric shock. LSC sections 9.1.2 requires all electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens where the receptacles are intended to serve the countertop surfaces. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and up to 10 residents. Findings include: Based on observation with the Maintenance Director on 07/12/16 between 11:35 a.m. and 11:47 a.m., the following outlets were discovered: a. Old Nurses' office storage room had an outlet eighteen inches away from a water source and did not have GFCI protection. b. Rehabilitation lounge bathroom GFCI outlet failed to trip when tested.		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1. Immediate actions taken for those residents identified:** No residents were identified in this citation. **2. How the facility identified other residents:** Residents located in areas noted in this citation have the potential to be affected by this alleged deficient practice.	

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	c. Room 159 in Rehabilitation bathroom GFCI outlet failed to trip when tested. Based on observation with the Maintenance Director on 07/13/16 at 9:56 a.m., the Upper Manor- Linden clean utility room had an outlet ten inches away from a water source without GFCI protection. Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 multiplug and 4 of 4 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 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 38 residents. Findings include: Based on observation with Maintenance Director on 07/12/15 at 3:40 p.m., a surge protector was powering another surge protector powering electronic devices in		**3. Measures put into place/ System changes:** GFCI receptacles were replaced/installed to: Old nurse's office storage room. Rehabilitation lounge bathroom. Resident room 159 bathroom. Upper Manor Linden unit clean utility room. The double surge protectors in the Upper Maple Nurses Station was replaced with one surge protector. The multi plug was removed from the Dining Room. The refrigerators in the MDS and the Activity offices were connected directly to an outlet. The extension cord in the upper Pines nurse's station medication room was removed and the refrigerator was connected directly to an outlet. The electrical outlet plate was replaced in the upper Pines nurse's station. Staff were in-serviced for electrical compliance concerning surge protectors, covered outlets, GFCI	

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	the Upper Maple Nurses' station. Based on observation with Maintenance Director on 07/13/15 between 10:38 a.m. to 10:46 a.m., the following was discovered: a. A multiplug was powering a surge protector powering television equipment in the Dining Room. b. A surge protector was powering a refrigerator in the MDS office c. A surge protector was powering a refrigerator in the Activity Director's office d. An extension cord was powering a surge protector powering a refrigerator in the Upper Pines Nurses' station medication room. Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain 1 of 2 electrical outlets in the Upper Pines Nurses' station. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff only because the wing is not occupied.		receptacles, extension cords and appliances that have to be connected directly into wall outlets. Guardian Angels/managers will audit a minimum of 10 rooms/areas weekly for compliance. **4. How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months **5. Date of compliance: 8/12/2016**	

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	Findings include: Based on observations with the Maintenance Director on 07/13/16 at 10:27 a.m., an electrical outlet plate was damaged with pieces missing in the Upper Pines Nurses' station. Based on interview at the time of observation, Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)			
K 0211 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers shall have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623 Based on observation and interview, the facility failed to ensure 1 of 1 alcohol	K 0211	**The facility requests paper compliance for this citation.**	08/12/2016

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	based hand sanitizers near the Front Entrance was not installed above or near an ignition source. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Director on 07/12/16 at 11:30 a.m., an alcohol based hand sanitizer dispenser was mounted on the wall directly above a wheelchair button near the Front Entrance. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** No residents were identified in this citation. **2) How the facility identified other residents:** This common area would not directly affect any residents. **3) Measures put into place/ System changes:**	

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			The hand sanitizer dispenser was relocated for compliance. An inspection of all areas of the facility were completed by the maintenance director and the surveyors with no other concerns noted. Any changes of location or installation of hand sanitizer dispensers will be inspected by the Director of Plant Operations/designee for compliance. Any findings of non-compliance will be corrected and reported to the Quality Assurance Committee. **4) How the corrective actions will be monitored:** Findings of non-compliance will be reviewed by the Quality Assurance Committee for further recommendations for action required for compliance. **5) Date of compliance: 8/12/2016**	