STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155771	A. BUILDING -- B. WING	10/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE	1070 W JEFFERSON ST FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date(s): 10/09/18 & 10/10/18 Facility Number: 001127 Provider Number: 155771 AIM Number: 200247220 At this Emergency Preparedness survey, Otterbein Franklin Senior Life Comm Res & Com Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. Quality Review completed on 10/15/18 - DA The facility has 208 certified beds. At the time of the survey, the census was 166.	E 0000		
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 483.90(a). Survey Date(s): 10/09/18 & 10/10/18 Facility Number: 001127 Provider Number: 155771 AIM Number: 200247220 At this Life Safety Code Survey, Otterbein	K 0000	On October 10, 2018, a Life Safety Code with Emergency Preparedness Survey was conducted at Otterbein Franklin Seniorlife Community Residential & Comprehensive Care by the Division of Long Term, Indiana State Department of Health. As a result of this Survey, the Surveyors alleged that the Community was not in substantial compliance with certain Medicare	

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

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	Franklin Senior Life Comm Res & Com Care was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. Otterbein Franklin Senior Life Comm Res & Com Care consists of four separate but connected buildings constructed at four different times: Building 1 an NCC facility built in 1957, is a three story sprinklered building of Type I (332) construction with a basement; Building 2 built in 1980 is a three story sprinklered building of Type I (332) construction with a basement; Building 3 built in 1992 is a one story sprinklered building of Type I (332) construction with a basement; and Building 4 built in 2000 is a three story sprinklered building of Type I (332) construction. Because all buildings are of the same type of construction, the facility was surveyed as one building. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. In Building 2, 47 battery operated detectors were provided in resident rooms in Health Center 2 and Health Center 3. All other resident rooms in Building 2 are provided with hard wired smoke detectors. In Building 3 and Building 4, hard wired smoke detectors are installed in all resident rooms. The healthcare portion of the facility has a capacity of 208 and had a census of 166 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 10/15/18 - DA		and Medicaid certification requirements. Preparation and submission of this Plan of Correction does not constitute the admission or agreement by the Provider to the truth of the “findings” alleged or conclusions set forth in the Statement of Deficiencies (CMS-2567). The Plan of Correction is prepared and executed and submitted solely because it is required by the provisions of federal and state law. Please consider this Plan of Correction to be the Community’s credible allegation of compliance. The Community will achieve substantial compliance with the applicable certification requirements by November 9, 2018. Please notify me immediately if you do not find the Plan of Correction to be written credible evidence of the Community’s substantial compliance with the applicable requirements as of this date. In that event, I would be more than pleased to provide you with an additional evidence of compliance so that may certify that the Community is in substantial compliance with the applicable requirements. The Community requests a desk review to verify that the Community achieved substantial compliance with the applicable requirements as of the dates set	

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			forth in this Plan of Correction and credible allegation of compliance. **The Provider formally requests a desk review of this Plan of Correction.**	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of over 15 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Manager and the Administrator during a tour of the facility from 1:20 p.m. to 3:20 p.m. on 10/09/18, a plastic three drawer chest of drawers for isolation supplies was stored in the corridor outside Room 206 and Room 224 in Building 2 on the second floor. Each chest of drawers projected one foot into the eight foot wide corridor. Based on interview at the time of the observations, the Maintenance Manager agreed the aforementioned means of egress were not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 0211	K 211 / MEANS OF EGRESS 1.All three plastic chest drawers used for isolation supplies had the wheels stored in the one of the drawers. The wheels were installed with epoxy so that they are not able to be removed. 2.No other residents were identified to be affected by this deficient practice. 3.Moving forward, all plastic chest drawers that are purchased will have the wheels installed with epoxy before being used. 4.The Director of Nursing or their Designee will in-service the Maintenance Director, Housekeeping Director, and Medical Supply Clerk that prior to putting any plastic storage drawers on the “floor” the wheels need to be installed in such a manner that the wheels can’t be	11/09/2018

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	3.1-19(b)		removed. The Director of Nursing or their Designee will audit weekly for six months and report to the QAPI Committee to ensure that there are no plastic storage drawers being used without wheels. 5.The Systemic changes will be completed by November 9, 2018.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised			

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	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. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 2 of over 15 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means	K 0222	K 222 / EGRESS DOORS 1.The corridor door to the stairwell enclosure by Room 356 in Building 4 on the third floor and the corridor door to the stairwell	10/25/2018

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	of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 20 residents, staff and visitors in Building 4. Findings include: Based on observations with the Maintenance Manager and the Assistant Director of Nursing (ADON) during a tour of the facility from 9:30 a.m. to 11:40 a.m. on 10/10/18, the corridor door to the stairwell enclosure by Room 356 in Building 4 on the third floor and the corridor door to the stairwell enclosure by Room 266 in Building 4 on the second floor in the Alzheimer's wing were each marked as a facility exit, the exit door could be opened by sliding an employee access card at the exit but each door failed to open when the Maintenance Manager's access card was swiped multiple times. During the tour, the Maintenance Manager's access card, the ADON's access card and the access card for an employee on duty in the Alzheimer's wing were also swiped multiple times at the exit door by Room 266 but each time the door failed to open. Based on interview at the time of the observations, the Maintenance Manager stated the stairwell doors are also equipped with magnetic holding devices which release with fire alarm system activation, all staff on duty have access cards to open the doors but agreed the aforementioned stairwell exit doors failed to open when the access cards were swiped multiple times. 3.1-19(b)		enclosure by Room 266 in Building 4 on the second floor in the Alzheimer's wing were both repaired by a technician from an outside vendor. The doors now release when an access card is used at the card reader for the corresponding door. 2.All other doors were inspected and no doors were found to be non-working. No other residents were identified to be affected by this deficient practice. 3.The Maintenance Director or their Designee will check each door weekly to ensure that the access card system is functioning properly. 4.The Maintenance Director or their Designee will audit weekly by using a PM Checklist to ensure compliance. The Maintenance Director or their Designee will report to the QAPI Committee monthly for six months to ensure ongoing compliance. 5.The Systemic changes were completed on October 25, 2018.	

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K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 2 battery backup lights were tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect over 15 residents, staff and visitors in the vicinity of Room 2 in Building 3 on the first floor. Findings include: Based on review of "Emergency Light Battery Test" documentation with the Maintenance Manager during record review from 9:10 a.m. to 12:50 p.m. on 10/09/18, monthly functional and annual 90 minute testing for one battery operated backup light located at the emergency generator location inside the building was noted. Based on observations with the Maintenance Manager and the Assistant Director of Nursing (ADON) during a tour of the facility from 9:30 a.m. to 11:40 a.m. on 10/10/18, one additional battery backup lighting system affixed to an exit sign was noted in	K 0291	K 291 / EMERGENCY LIGHTING 1.“Emergency Light Battery Test” documentation for the system affixed to the exit sign in Building 3 on the first floor outside Room 2 will be included in the monthly and annual testing documentation. 2.All other Emergency Light Battery Back-ups were determined to be included in the monthly and annual testing documentation. No other residents were identified to be affected by this deficient practice. 3.All Emergency Light Battery Back-ups will be checked and documented monthly and annually by the Maintenance Director or their Designee. 4.The Maintenance Director or their Designee will audit to ensure that documentation both monthly and annually on all Emergency Light Battery Back-up is occurring. Maintenance Director or their Designee will report to the QAPI Committee monthly for six months to ensure ongoing compliance. 5.The Systemic Changes were completed on October 23, 2018.	10/23/2018

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	Building 3 on the first floor outside Room 2. The lighting system functioned when its test button was pushed. Based on an interview at the time of the observations, the Maintenance Manager stated the light outside Room 2 is not included in monthly and annual testing documentation and agreed monthly and annual testing documentation for the battery lighting system outside Room 2 for the most recent twelve month period was not available for review. 3.1-19(b)			
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation and interview; the facility failed to ensure documentation for the preventative maintenance of all battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect over 40 residents, staff, and visitors in Building 2.	K 0300	K 300 / Protection 1.The battery operated smoke detector in Room 326 was cleaned and documentation has occurred. 2.All other battery operated smoke detectors have been cleaned and documentation has occurred. All residents were identified to be affected by this deficient practice. 3.All battery operated smoke detectors will be cleaned and documentation will occur on a monthly basis. 4.The Maintenance Director or their Designee will audit to ensure that documentation on the	10/18/2018

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	Findings include: Based on review of "Weekly Smoke Alarm Test" documentation with the Maintenance Manager during record review from 9:10 a.m. to 12:50 p.m. on 10/09/18, battery operated smoke detector cleaning documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Manager states housekeeping staff regularly clean the resident room battery operated smoke detectors but the cleanings are not documented. Based on observations with the Maintenance Manager and the Administrator during a tour of the facility from 1:20 p.m. to 3:20 p.m. on 10/09/18 and from 9:30 a.m. to 11:40 a.m. on 10/10/18, battery operated smoke detectors are installed in resident rooms in Building 2 on the second and third floors. Manufacturer's documentation affixed to the First Alert Model SA340 battery operated smoke detector installed in Room 326 stated to clean the detector once per month. Based on interview at the time of the observations, the Maintenance Manager stated the same model smoke detector is installed in each resident room in Building 2 and agreed battery operated smoke detector cleaning documentation was not available for review. 3.1-19(b)		cleaning of all battery operated smoke detectors is occurring. The Maintenance Director or their Designee will report to the QAPI Committee monthly for six months to ensure ongoing compliance. 5.The Systemic Changes were completed by October 18, 2018.	
K 0531 SS=E Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's			

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	Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3			
	Based on record review, observation and interview; the facility failed to document testing of 2 of 2 elevator firefighter's service recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice could affect over five residents, staff and visitors. Findings include: Based on record review with the Maintenance Manager from 9:10 a.m. to 12:50 p.m. on 10/09/18, monthly elevator recall testing documentation was not available for review. Based on interview at the time of record review, the Maintenance Manager stated the facility has two elevator machine rooms, an elevator contractor performs all elevator recall testing and recall testing documentation is	K 0531	K 531 / Elevators 1.The Maintenance Director or their Designee will have the contractor return back to the Community to provide the most recent documentation of the monthly firefighter's service recall testing for all elevators. 2.Documentation will be obtained from contractor that all other elevators will have had the monthly firefighter's service recall testing performed. All residents were identified to be affected by this deficient practice. 3.All elevators will be tested to ensure that that the firefighter's service recall is properly operating. 4.The Maintenance Director or their Designee will audit monthly to ensure that the proper documentation exists from the contractor that the firefighter's	10/15/2018

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	located in the elevator machine rooms. Based on review of Thyssen Krupp's "Hydraulic Maintenance Tasks" documentation dated 2017 and 2018 with the Maintenance Manager and the Assistant Director of Nursing (ADON) during a tour of the facility from 9:30 a.m. to 11:40 a.m. on 10/10/18, documentation of monthly firefighter's service recall testing for elevators identified as 42265 and 42266 for December 2017 and January, March and September 2018 was not available for review. Based on interview at the time of the review, the Maintenance Manager agreed monthly elevator recall testing for the aforementioned monthly periods was not available for review. 3.1-19(b)		service recall testing has been performed. The Maintenance Director or their Designee will report to the QAPI Committee monthly for six months to ensure ongoing compliance. 5.The Systemic Changes were completed on October 15, 2018.	
K 0541 SS=E Bldg. 01	NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to			

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OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE	1070 W JEFFERSON ST FRANKLIN, IN 46131

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	discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 Based on observation and interview, the facility failed to maintain 1 of 1 laundry chutes and 1 of 1 rubbish chutes in accordance with NFPA 82, Standard on Incinerators and Waste and Linen Handling Systems and Equipment. LSC 9.5.2 requires laundry chutes shall be installed and maintained per NFPA 82, 2009 Edition. NFPA 82, Section 5.2.3.3.1.1 and Section 5.2.3.3.2.1 requires all chute loading doors shall be provided with a self-closing, positive latching frame and gasketed door assembly. This deficient practice could affect over twenty residents, staff and visitors in Building 2 on the second and third floor. Findings include: Based on observations with the Maintenance Manager and the Administrator during a tour of the facility from 1:20 p.m. to 3:20 p.m. on 10/09/18, the following was noted in the laundry and rubbish chute rooms on the second and third floor in Building 2: a. the laundry chute door on the second floor was not equipped with a latching mechanism to latch the door into the door frame which failed to allow the door to self close and latch into the door frame. The latching mechanism for the rubbish chute door in the room failed to work properly which also failed to allow the door to self close and latch into the door frame. b. the self closing devices for the laundry chute door and the rubbish chute door on the third floor chute room had been removed which failed to	K 0541	K 541 / Rubbish chutes, Incinerators, and Laundry Chutes 1.The laundry and rubbish chutes on the second and third floor in building 2 have been repaired to ensure that all doors properly self-close and a latching mechanisms have been installed on the door to ensure that the door properly latches. 2.All other laundry and rubbish chutes are were found to be properly functioning. All residents were found to be affected by this deficient practice. 3.The Maintenance Director or their Designee will inspect and document weekly to ensure that all doors to the laundry and rubbish chutes properly self-close and latch. 4.The Maintenance Director or their Designee will audit monthly to ensure that that proper documentation exists that each door on the laundry and rubbish chutes have been inspected on a weekly basis. The Maintenance Director or their Designee will report to the QAPI Committee monthly for six months to ensure ongoing compliance. 5.The Systemic Changes were	10/23/2018

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE	1070 W JEFFERSON ST FRANKLIN, IN 46131

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	allow each door to self close and latch into the door frame. Based on interview at the time of observation, the Maintenance Manager agreed the aforementioned laundry and rubbish chute doors in Building 2 on the second and third floors failed to self close and latch into the door frames. 3.1-19(b)		completed by October 23, 2018.	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o 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(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of over 50 rooms was maintained in accordance with 18.7.5.6. 18.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied.	K 0753	K 753 / Combustible Decorations 1.The corridor door located near Room 380 in building 2 has had the Halloween decorations that covered more than 50% of the door removed enough to cover less than 50% of the door. 2.All other corridor doors were checked to ensure that Halloween decorations were not covering	11/09/2018

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	(2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect over five residents, staff and visitors in the vicinity of Room 380 in Building 2 on the third floor. Findings include: Based on observations with the Maintenance		more than 50% of the door. No other residents were affected by this deficient practice. 3.The Maintenance Director or their Designee will inspect and document on a weekly basis to ensure that no corridor door is covered with more than 50% of any decorations. 4.The Maintenance Director or their Designee will audit monthly to ensure that the proper documentation exists that the corridor doors have been checked and documented that not 50% of door is covered by decorations. The Maintenance Director or their Designee will report to the QAPI Committee monthly for six month to ensure ongoing compliance. 5.The Systemic Changes will be completed by November 9, 2018.	

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	Manager and the Administrator during a tour of the facility from 1:20 p.m. to 3:20 p.m. on 10/09/18 and from 9:30 a.m. to 11:40 a.m. on 10/10/18, more than 50% of the corridor door to Room 380 in Building 2 on the third floor was covered with Halloween decorations consisting of paper, cotton and other miscellaneous materials for which fire retardant documentation was not attached to the decorations. Based on interview at the time of the observations, the Maintenance Manager stated the fire resistance rating of the decorations was not available for review, the decorations are not treated with fire retardant material and agreed more than 50% of the surface of the door on the corridor side of the door was covered with flammable decorations. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES			

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	loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review, observation and interview; the facility failed to maintain a complete written record of monthly generator load testing for 9 months of the most recent 12 month period. NFPA 99, Health Care Facilities Code, 2012 Edition, Chapter 6.4.4.1.1.4(A) requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110, 2010 Edition, Section 8.4.2.4 requires spark-ignited generator sets shall be exercised at least once a month with the available Emergency Power Supply Systems (EPSS) load for 30 minutes or until the water temperature and the oil pressure have stabilized. NFPA 99, Section 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors in the facility.	K 0918	K 918 / Electrical Systems 1.“Generator – Full Load Test” will occur for 30 minutes each month and documentation will be maintained to substantiate compliance. A minimum of a 5 minute cool down will occur each month after the “Generator – Full Load Test” and will be documented to substantiate compliance. 2.No residents were affected by this deficient practice. 3.The Maintenance Director or their Designee will ensure that documentation is maintained that the “Generator – Full Load Test” and the 5 minute cool down period is completed on a monthly basis. 4.The Maintenance Director or their Designee will audit the documentation regarding the “Generator – Full Load Test” and	11/09/2018

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	Findings include: Based on review of "Generator - Full Load Test" documentation dated 2018 with the Maintenance Manager during record review from 9:10 a.m. to 12:50 p.m. on 10/09/18, monthly load test documentation for 01/23/18 through 09/25/18 did not state the generator was operated for at least 30 minutes. Based on interview at the time of record review, the Maintenance Manager stated the emergency generator is normally exercised for 30 minutes during monthly load tests but agreed monthly load testing documentation for nine of the most recent twelve monthly load tests did not state the emergency generator was exercised for a minimum of 30 minutes. Based on observations with the Maintenance Manager and the Assistant Director of Nursing (ADON) during a tour of the facility from 9:30 a.m. to 11:40 a.m. on 10/10/18, the facility has one emergency generator which is diesel fired. Manufacturer's nameplate documentation affixed to the generator indicated it was rated at 500 kW. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a monthly load test for nine months of the most recent twelve month period. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110, 6.2.10 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to		the 5 minute cool down period to substantiate compliance. The Maintenance Director or their Designee will report to the QAPI Committee monthly for six months to ensure ongoing compliance. 5.The Systemic Change will be completed by November 9, 2018.	

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	shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Generator - Full Load Test" documentation dated 2018 with the Maintenance Manager during record review from 9:10 a.m. to 12:50 p.m. on 10/09/18, the cool down time period for emergency generator monthly load testing conducted 01/23/18 through 09/25/18 was not available for review. Based on interview at the time of record review, the Maintenance Manager stated the cool down time period is at least 5 minutes but agreed documentation of the cool down time period for monthly load testing in 2018 was not available for review. Based on observations with the Maintenance Manager and the Assistant Director of Nursing (ADON) during a tour of the facility from 9:30 a.m. to 11:40 a.m. on 10/10/18, the facility has one emergency generator which is diesel fired. Manufacturer's nameplate documentation affixed to the generator indicated it was rated at 500 kW. 3-1.19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet			

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	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 Based on observation and interview, the facility failed to ensure 3 of 3 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other	K 0920	K 920 / Electrical Equipment 1.The Community removed the 3 extension cords, including power strips, which were being used instead of fixed wiring. 2.No other residents were identified to be affected by this deficient practice. 3.The Maintenance Director or their Designee will inspect all areas and document on a weekly basis to ensure that extension cords or power strips that do not meet National Electrical Code are not used. 4.The Maintenance Director or their Designee will audit the documentation on a monthly basis to ensure weekly compliance. The Maintenance Director or their Designee will report to the QAPI Committee monthly for six months	11/09/2018

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	device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 15 residents, staff and visitors in the Building 2. Findings include: Based on observations with the Maintenance Manager and the Administrator during a tour of the facility from 1:20 p.m. to 3:20 p.m. on 10/09/18, the following was noted in Building 2: a. lighting for a small artificial Christmas tree was plugged into a power strip within the patient care vicinity three feet from the resident bed in Room 280 on the second floor. Manufacturer's documentation affixed to the power strip stated it was "UL 1449". b. a lamp and two cell phone chargers were plugged into a power strip within the patient care vicinity five feet from the resident bed in Room 381 on the third floor. Manufacturer's documentation affixed to the power strip stated it was "compliant with UL 1363". c. a cable television cable box, a television and a light for a curio were plugged into a power strip within the patient care vicinity three feet from the resident bed in Room 386 on third floor. Manufacturer's documentation affixed to the power strip stated it was "compliant with UL 1363". Based on interview at the time of the observations, the Maintenance Manager and the Administrator stated resident families bring in unauthorized power strips to the rooms but		to substantiate compliance. 5.The Systemic Change will be completed by November 9, 2018.	

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

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	order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 4 cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 3 oxygen storage rooms inside the facility. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 85 cubic meters (3000 cubic feet) shall comply with 5.1.3.3.2 and 5.1.3.3.3. NFPA 99, Section 5.1.3.3.2(7) requires cylinders be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full or empty. This deficient practice could affect over 5 residents, staff and visitors in the vicinity of the oxygen storage room and transfilling room by 280 in Building 2 on the second floor. Findings include: Based on observations with the Maintenance Manager and the Administrator during a tour of the facility from 1:20 p.m. to 3:20 p.m. on 10/09/18 and from 9:30 a.m. to 11:40 a.m. on 10/10/18, one of four oxygen cylinders were freestanding on the floor in the oxygen storage room and transfilling room by 280 in Building 2 on the second floor and were not supported in a proper cylinder stand or otherwise secured from falling. Two liquid oxygen containers and four oxygen cylinders were	K 0923	K 923 / Gas Equipment 1.One of four oxygen cylinders that were free standing on the floor in the Oxygen Storage Room was secured and prevented from falling. 2.No residents were found to be affected by this deficient practice. 3.The Maintenance Director or their Designee will inspect all oxygen rooms and document on a weekly basis to ensure that all oxygen cylinders are stored in a secured manner. 4.The Maintenance Director or their Designee will audit the documentation on a monthly basis to ensure weekly compliance. The Maintenance Director or their Designee will report the QAPI Committee monthly for six months to substantiate compliance. 5.The Systemic Change will be completed by November 9, 2018.	11/09/2018

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	observed stored in the room. Based on interview at the time of the observations, the Maintenance Manager agreed the aforementioned oxygen cylinder was not supported in a cylinder stand or otherwise secured from falling. 3.1-19(b)			