STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

K 054
NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3

This STANDARD is not met as evidenced by:
Based on observation, it was determined the facility failed to ensure that 1 of 62 (200 D hall utility room) smoke detectors had the required clearance from supply air and return and exhaust vents.

The findings included:
Observations of the 200 D hall utility room on 2/13/12 at 10:30 AM, revealed the smoke detector had been installed within 3 feet of the exhaust vent.

This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 2/13/12.

K 104
NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.

This STANDARD is not met as evidenced by:
Based on observation, it was determined the facility failed to maintain rated assemblies.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
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The findings included:

Observations above the ceiling over the 3 hour fire doors on the 200 hall by the staff development office on 2/13/12 at 3:00 PM, revealed penetrations around the low voltage cable above both sides of the door.

This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 2/13/12.

K104  03/02/2012

1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

On 2.13.12, maintenance director repaired penetrations above the ceiling over the 3-hour fire doors on the 200 hall by the staff development office. Proper caulking was utilized. Facility is now in compliance.

2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

On 2.13.12, maintenance director conducted review of facility to ensure that no other penetrations existed. Review revealed that there were no other penetrations.

3) What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?

Maintenance director or designee will conduct review of facility for fire penetrations of wall spaces monthly for three months till 100% compliance is achieved.

4) How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?

Maintenance director will present findings of reviews to the Performance Improvement Committee monthly. Performance Improvement Committee consists of: Medical Director, Executive Director, Director of Nursing, Business Office Manager, Dietary Manager, Activities Coordinator, Health Information Manager, Rehab Services Manager, Social Services Director, Environmental Services Director, Marketing Director, Admissions Coordinator, Wound Care Nurse, Maintenance Director and Assistant Director of Nursing. Performance Improvement Committee will provide recommendations as necessary.