K 018  NFPA 101 LIFE SAFETY CODE STANDARD

SS=D

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3

Roller latches are prohibited by CMS regulations in all health care facilities.

This STANDARD is not met as evidenced by:
Based on observation, it was determined the facility failed to maintain corridor doors in 1 of 6 (E corridor) corridors.

The findings included:
Observations on E corridor on 4/23/12 at 11:30 AM, revealed the linen closet door on E corridor did not positive latch.

This finding was verified by the maintenance director and the facility administrator during the exit conference on 4/23/12.

1. Linen closet door on corridor "E" will have a positive latch.
2. Upon examination of the linen closet on corridor "E" the striker plate was found to be loose in the frame causing the door not to latch.
3. The striker plate was aligned, screws tightened and door closing was inspected to ensure positive latch.
4. All linen closet doors will be examined to ensure they positive latch.
5. Should any doors be found to not positive latch they will be repaired immediately.
6. A positive latch log has been implemented to ensure all facility doors are latching properly. Positive latching checks will be made periodically by the Maintenance Director and the results will be entered in the log.
7. This corrective action will be monitored by the Maintenance Director who will report any unresolved discrepancies to the QA&A Committee for further investigation and action indicated.
8. Completed on 4/24/12.

Note: The 2567 states that the “findings were verified by the maintenance director and the administrator during the exit
conference on 4/23/12." The aforementioned statement is incorrect. The findings were not verified by the maintenance director and administrator, however, many of the items noted in the 2567 were discussed with the maintenance director and administrator during the exit conference on 4/23/12.
### K 025 \( \text{NFPA 101 LIFE SAFETY CODE STANDARD} \)

**SS=F:**

Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

This STANDARD is not met as evidenced by:

Based on observations, it was determined the facility failed to maintain the smoke barriers in 5 of 6 (A, C, D, E and F corridors) corridors.

The findings included:

1. Observations on 4/23/12 at 11:35 AM, revealed the following penetrations around sprinklers in the following locations:
   a. Mail room at corridor A.
   b. Corridor A outside rooms 101, 102, 104 and 108.
   c. Physical therapy room in corridor A.
   d. Wheelchair storage area in corridor A.
   e. Corridor C near nurses station.
   f. Restorative Care office in corridor C.
   g. Above door between clean and dirty laundry rooms.
   h. In dining room near door to corridor D.
   i. Entrance to kitchen above ice machine.
   j. Outside mechanical room in corridor D.

   1. The facility will maintain the smoke barriers in A, C, D, E, F corridors.
   2. The escutcheon covers around the sprinkler heads at the following locations were properly sealed at the ceiling:
   a. Mall room at corridor A.
   b. Corridor A outside rooms 101, 102, 104 and 108.
   c. Physical therapy room in corridor A.
   d. Wheelchair storage area in corridor A.
   e. Corridor C near the nurses station.
   f. Restorative Care office in corridor C.
   g. Above door between clean and dirty laundry rooms.
   h. In dining room near door to corridor D.
   i. Entrance to kitchen above ice machine.
   j. Outside mechanical room in corridor D.
   k. Inside staff development coordinator office in corridor D.
   l. Inside electrical closet in corridor D.
   m. Bathroom in room 605.
n. Corridor F outside room 605.

3. A review of all facility escutcheon covers has been conducted. All escutcheon covers found to need correction were adjusted to the proper position.

4. A quality assurance check of escutcheon covers has been implemented. Checks will be conducted periodically, the results logged and corrective action taken immediately by the Maintenance Director if warranted.

5. This corrective action will be monitored by the Maintenance Director who will report any unresolved discrepancies to the QA&A Committee for further investigation and action if indicated.

#2

1. Smoke Barrier Penetrations – The smoke barrier penetrations in the following areas were repaired using 3M Fire Barrier Caulk CP25WB+.
   a. Around the smoke detector in corridor C outside room 309.
   b. Around pipe through ceiling near door in dryer access room.
c. Around ethernet cable in medical record room.

d. Around the conduit at entrance to sprinkler room

e. Smoke detector in corridor E outside room S04

2. All smoke barriers in the facility were inspected and repaired as needed using 3M Fire Barrier Caulk CP25WB+.

3. A quality assurance check of smoke barriers has been implemented. Checks will be conducted periodically, the results logged and corrective action taken immediately by the Maintenance Director if warranted.

4. This corrective action will be monitored by the Maintenance Director who will report any unresolved discrepancies to the QA&A Committee for further investigation and action if indicated.

5. Completed 4/27/12

Note: The 2567 states that the “findings were verified by the maintenance director and the administrator during the exit conference on 4/23/12.” The aforementioned statement is incorrect. The findings were not verified by the maintenance director and administrator,
K 025  Continued From page 2

k. Inside staff development coordinator office in corridor D.
l. Inside electrical closet in corridor D.
m. Bathroom in room 505.
n. Corridor F outside room 605.

2. Observation on 4/23/12 at 12:20 PM, revealed penetrations in the smoke barrier in the following locations:
a. Around smoke detector in corridor C outside room 309.
b. Around pipe through ceiling near door in dryer access room.
c. Around ethernet cable in medical record room.
d. Around conduit at entrance to sprinkler room.
e. Smoke detector in corridor E outside room 504.

These findings were verified by the maintenance director and the facility administrator during the exit conference on 4/23/12.

K 029  NFPA 101 LIFE SAFETY CODE STANDARD SS=D:

One hour fire rated construction (with ¾ 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

K 025  however, many of the items noted in the 2567 were discussed with the maintenance director and administrator during the exit conference on 4/23/12.

K 029  K029

1. The gas pipeline in the F hall mechanical room will not have a penetration in the area where it penetrates the wall.

2. The penetration around the gas pipeline in F hall mechanical room was sealed using 3M Fire Barrier Sealant CP25WB.

3. A review of all gas pipeline penetrations in the facility was conducted to ensure penetrations are properly sealed.

4. A quality assurance check list has been put in place using the daily Maintenance Log Sheet.
5. A quality assurance check of gas pipeline penetrations has been implemented. Checks will be conducted periodically, the results logged and corrective action taken immediately by the Maintenance Director if warranted.

6. This corrective action will be monitored by the Maintenance Director who will report any unresolved discrepancies to the QA&A Committee for further investigation and action if indicated.

7. Completed 4/24/12

Note: The 25G7 states that the “findings were verified by the maintenance director and the administrator during the exit conference on 4/23/12.” The aforementioned statement is incorrect. The findings were not verified by the maintenance director and administrator, however, many of the items noted in the 25G7 were discussed with the maintenance director and administrator during the exit conference on 4/23/12.
K 029  Continued From page 3
This STANDARD is not met as evidenced by:
Based on observation, it was determined the facility failed to maintain the required separation in hazardous areas in 1 of 6 (F corridor) corridors.

The findings included:

Observation on 4/23/12 at 1:16 PM, revealed a penetration around the gas pipe in mechanical room in the F corridor.

This findings was verified by the maintenance director and the facility administrator during the exit conference on 4/23/12.

K 050  NFPA 101 LIFE SAFETY CODE STANDARD

Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine.

Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms.  19.7.1.2

This STANDARD is not met as evidenced by:
Based on observations, it was determined the facility failed the fire drill.

The findings included:

Observations during the fire drill on 4/23/12 at 11:29 AM, revealed staff member number #1 did not announce the location of the fire.

K 050

1. Staff members will announce the location of the fire during drills or actual fires.
2. Staff members will not re-enter a room of a fire after the door is closed.
3. An in-service will be conducted by the Maintenance Director and/or Staff Development Coordinator for all employees to review all steps to be taken and procedures to be followed during a fire drill or actual fire (including announcement of the location of the fire and not reentering the room where the fire is located).
4. All fire drills will be reviewed after completion to ensure staff properly announces location and do not reenter room where the fire is located. If staff does not announce the location or
reenters the room the drill will be repeated until performed correctly.

5. This corrective action will be monitored by the Maintenance Director who will report any unresolved discrepancies to the QA&A Committee for further investigation and action if indicated.

6. Completed 5/20/12.

Note: The 2567 states that the “findings were verified by the maintenance director and the administrator during the exit conference on 4/23/12.” The aforementioned statement is incorrect. The findings were not verified by the maintenance director and administrator, however, many of the items noted in the 2567 were discussed with the maintenance director and administrator during the exit conference on 4/23/12.
K 050  Continued From page 4

Observation during the fire drill on 4/23/12 at 11:31 AM, revealed that several staff members reentered the room of the fire after the door was closed.

These findings were verified by the maintenance director and the facility administrator during the exit conference on 4/23/12.

K 052  NFPA 101 LIFE SAFETY CODE STANDARD
SS=E

A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4

This STANDARD is not met as evidenced by:
Based on testing, it was determined the facility failed to maintain the fire alarm system.

The findings included:

Testing of the fire alarm system on 4/23/12 at 1:45 PM, revealed that no visible trouble alarm appeared on the fire alarm control panel when the secondary phone line was disconnected. The fire alarm monitoring company did receive a trouble signal and called to notify the facility.

K 052  K052

1. The trouble alarm will appear on the fire control panel display screen when the primary or secondary phone line is disconnected.

2. On 4/27/12 Access Control System ordered and will install a model UDACT2 Digital Communicator to interface with the Notifier Onyx 640 Fire Alarm System to ensure a visible trouble alarm appears on the fire control panel display screen when the primary or secondary phone line is disconnected.

3. The Maintenance Director will periodically monitor the fire control panel display screen while disconnecting the primary and secondary phone lines to ensure a visible trouble alarm appears on the fire control panel display screen when the primary or secondary phone line is disconnected and to ensure the
4. Should the fire control panel display screen fail to display trouble while disconnecting the primary and secondary phone lines or fire alarm monitoring company fail to call the facility the problem will be reported and repaired immediately.

5. This corrective action will be monitored by the Maintenance Director who will report any unresolved discrepancies to the QA&A Committee for further investigation and action if indicated.

Note: The 2567 states that the "findings were verified by the maintenance director and the administrator during the exit conference on 4/23/12." The aforementioned statement is incorrect. The findings were not verified by the maintenance director and administrator, however, many of the items noted in the 2567 were discussed with the maintenance director and administrator during the exit conference on 4/23/12.
K 052  Continued From page 5

Testing of the fire alarm system on 4/23/12 at 1:51 PM, revealed that no visible trouble alarm appeared on the fire alarm control panel when the primary phone line was disconnected. The fire alarm monitoring company did receive a trouble signal and called to notify the facility.

These findings were verified by the maintenance director and the facility administrator during the exit conference on 4/23/12.

K 062  NFPA 101 LIFE SAFETY CODE STANDARD SS=D

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

This STANDARD is not met as evidenced by:
Based on observation, it was determined the facility failed to properly maintain the automatic sprinkler system.

The finding includes:

Observation of the spare sprinkler cabinet on 4/23/12 at 12:55 PM, revealed the facility did not have spare sprinklers for all types of sprinklers installed in the facility.

The finding was verified by the maintenance director and facility administrator during the exit conference on 4/23/12.

K 067  NFPA 101 LIFE SAFETY CODE STANDARD SS=D

1. The spare sprinkler cabinet will contain spare sprinklers of all types installed in the facility.
2. An adequate supply of sprinkler heads of all types installed in the facility were ordered and will be maintained at all times.
3. The Maintenance Director will periodically monitor the spare sprinkler cabinet to ensure it contains an adequate supply of sprinkler heads of all types. Should the spare sprinkler cabinet not have an adequate supply of sprinkler heads, they will be ordered immediately.
4. This corrective action will be monitored by the Maintenance Director who will report any unresolved discrepancies to the QA&A Committee for further investigation and action if indicated.

Note: The 2567 states that the “findings were verified by the maintenance director and the administrator during the exit conference on 4/23/12.” The aforementioned statement is incorrect. The findings were not verified by the maintenance director and administrator, however, many of the items noted in the 2567 were discussed with the maintenance director and administrator during the exit conference on 4/23/12.
K 067  Continued From page 6

Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2

This STANDARD is not met as evidenced by:

Based on testing, it was determined the facility failed to maintain negative pressure in required areas.

The findings included:

1. Testing on 4/23/12 at 12:27 PM, revealed there was not a negative pressure maintained in the dirty laundry area.

2. Testing on 4/23/12 at 12:30 PM, revealed there was not a negative pressure maintained in the infectious waste room at the end of corridor C.

These findings were verified by the maintenance director and the facility administrator during the exit conference on 4/23/12.

K 069  NFPA 101 LIFE SAFETY CODE STANDARD

SS=E

Cooking facilities are protected in accordance with 9.2.3, 19.3.2.6, NFPA 96

This STANDARD is not met as evidenced by:

Based on observations and record review, it was determined the facility failed to properly protect cooking facilities.

K 067  K 067

1. There will be negative air pressure in the dirty laundry room and in the infectious waste room in Corridor C.

2. Upon inspection of the exhaust system which provides negative air pressure in the dirty laundry room and in the infectious waste room in Corridor C, a pulley belt was found to be broken and a new belt was installed.

3. Inspections were conducted of all facility exhaust fans to ensure proper operation. All exhaust fans were found to be in proper operating condition.

4. The Maintenance Director will periodically monitor all exhaust fans, document findings in the facility log book and make any needed repairs immediately.

5. This corrective action will be monitored by the Maintenance Director who will report any unresolved discrepancies to the QA&A Committee for further investigation and action if indicated.

Note: The 2557 states that the "findings were verified by the maintenance director and the administrator during the exit conference on 4/23/12." The aforementioned statement is incorrect. The findings were not
verifed by the maintenance director and administrator, however, many of the items noted in the 2567 were discussed with the maintenance director and administrator during the exit conference on 4/23/12.
K 069 Continued From page 7

The findings included:

1. Observation in the kitchen on 4/23/12 at 12:42 PM, revealed a portable deep fryer not protected by a hood extinguishing system.

2. Observations in the kitchen on 4/23/12 at 12:43 PM, revealed the grill and stove were not centered under hood fire extinguishing nozzles.

3. Record review on 4/23/12 at 2:08 PM, revealed the facility failed to conduct the semi-annual range hood inspection that was due in December of 2011.

These findings were verified by the maintenance director and the facility administrator during the exit conference on 4/23/12.

K 130 NFPA 101 MISCELLANEOUS

OTHER LSC DEFICIENCY NOT ON 2786

This STANDARD is not met as evidenced by:
National Fire Protection Association (NFPA) 101, 8.2.3.2.4.2
Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:
(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:
a. it shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.

K 069 K069
1. The portable deep fryer will be protected by the hood extinguishing system.

2. Observation revealed the grill and stove were not centered under the hood fire extinguishing nozzles.

3. Record review revealed that the facility's contracted service performed a range hood inspection in June, 2011 and March, 2012, however the dates of service did not meet the dates to fulfill the requirement to conduct semi-annual range hood inspections.

4. New electrical cords that are longer in length were installed on the portable deep fryer thereby allowing the unit to sit under the anslul hood system when in use.

5. The range was centered under the fire extinguishing nozzles and kitchen staff was instructed on proper placement of the range after cleaning.

6. Maintenance logs will be implemented and monitored by the Maintenance Director to ensure proper positioning of the stove, proper positioning of the fryer and timely anslul hood inspections. All documentation will be kept in the facility log book.
7. This corrective action will be monitored by the Maintenance Director who will report any unresolved discrepancies to the QA&A Committee for further investigation and action if indicated.

Note: The 2567 states that the "findings were verified by the maintenance director and the administrator during the exit conference on 4/23/12." The aforementioned statement is incorrect. The findings were not verified by the maintenance director and administrator, however, many of the items noted in the 2567 were discussed with the maintenance director and administrator during the exit conference on 4/23/12.
K 130 Continued From page 8

b. It shall be protected by an approved device that is designed for the specific purpose.

(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions:

a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.

b. It shall be protected by an approved device that is designed for the specific purpose.

(3) * Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met:

a. The material shall be capable of maintaining the fire resistance of the fire barrier.

b. The material shall be protected by an approved device that is designed for the specific purpose.

(4) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions:

a. It shall be made on either side of the fire barrier.

b. It shall be made by an approved device that is designed for the specific purpose.

This STANDARD is not met as evidenced by:

Based on observations, it was determined the facility failed to maintain the fire walls in 5 of 6 (A, B, C, E and F corridors) corridors.

The findings included:

Observations on 4/23/12 at 10:30 AM, revealed the following fire walls located in the attic had penetrations:

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
<th>Date of Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>K130</td>
<td>5/14/12</td>
<td>1. The facility will maintain fire walls in corridors A, B, C, E, F.</td>
<td>1. Corridors A, B, C, E, F contained penetrations around conduits with cable, ethernet, cable, flex conduit, and sprinkler pipes and were sealed with 3M Block Foam.</td>
<td>5/14/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Corridors A, B, C, E, F contained penetrations around conduits with cable, ethernet, cable, flex conduit, and sprinkler pipes and were sealed with 3M Block Foam.</td>
<td>3. The drywall tape that was peeling was removed, new tape and drywall mud was used to seal the gaps between the boards of sheetrock.</td>
<td>5/14/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. The drywall tape that was peeling was removed, new tape and drywall mud was used to seal the gaps between the boards of sheetrock.</td>
<td>4. The F hall fire door located in the attic is now closing automatically with a tension spring.</td>
<td>5/14/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. The F hall fire door located in the attic is now closing automatically with a tension spring.</td>
<td>5. This corrective action will be monitored by the Maintenance Director who will report any unresolved discrepancies to the QA&amp;A Committee for further investigation and action if indicated.</td>
<td>5/14/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. This corrective action will be monitored by the Maintenance Director who will report any unresolved discrepancies to the QA&amp;A Committee for further investigation and action if indicated.</td>
<td>Completed 5/14/12</td>
<td>5/14/12</td>
</tr>
</tbody>
</table>

Note: The 2567 states that the "findings were verified by the maintenance director and the administrator during the exit conference on 4/23/12." The aforementioned statement is incorrect. The findings were not verified by the maintenance director and administrator, however, many of the items noted in the 2567 were discussed with the maintenance director and administrator during the exit conference on 4/23/12.
K 130 Continued from page 9
a. Corridor E had a conduit with ethernet cable that was not sealed,
b. Corridor E had drywall tape peeling off revealing the gap between boards,
c. Corridor F had drywall tape peeling off revealing the gap between boards,
d. Corridor F had a fire door open,
e. Corridor F had penetration around sprinkler pipe,
f. Corridor F had conduit sealed improperly,
g. Corridor F had penetration around flex conduit,
h. Corridor A had a penetration around sprinkler pipe,
i. Corridor A had a conduit with cable and ethernet lines that was not sealed,
j. Corridor A had a section of drywall replaced and was not correctly sealed,
k. Corridor A had penetration around Ethernet cable through wall,
l. Corridor B had four conduits sealed with improper sealant,
m. Corridor B had penetration around section of drywall that was replaced,
n. Corridor C had penetrations around sprinkler pipe and flex conduit,

These findings were verified by the maintenance director and the facility administrator during the exit conference on 4/23/12.