**STANDARD:** NFPA 101 LIFE SAFETY CODE STANDARD

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.

This STANDARD is not met as evidenced by:

Based on observation, it was determined that the facility failed to assure that air handling units shut down when the fire alarm system went into general alarm.

The findings included:

Observations of the facility during the fire alarm on 12/19/11 at 12:30 PM, revealed air handler number 8 feeding the 300 and 400 corridor, and air handler number 1, feeding the 100-200 corridor did not shut down when the general alarm was activated.

This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 12/19/11.

**K 052**

The facility will assure that air handling units shut down when the fire alarm system goes into general alarm.

Corrective Action:

Outside contractors have been notified to inspect and repair issues preventing air handlers number 1 & 8 from shutting down when the fire alarm system went into general alarm.

The outside contractors and the maintenance department will do a thorough check of entire facility to ensure all air handlers shut down when the fire alarm system goes into general alarm.

Identification of the residents with potential to be affected:

All residents have the potential to be affected by this practice.

Measure/systemic changes put into place to ensure the deficient practice does not recur:

The maintenance staff were in-serviced on 12/22/11 on the operation of the fire alarm system and the need to shut down the air handling system during the activation of the fire alarm system.

The maintenance department will verify proper operation of the system, ensuring the air handlers are shutting down throughout the facility, as part of the ongoing fire drill procedures.

How the corrective action will be monitored to ensure the deficient practice will not recur:

Results of the fire drill procedures to ensure the air handlers are shutting down during the fire drill procedures will be reported monthly to the Quality Assurance committee for review and recommendations to ensure compliance with this regulation.

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*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 50 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.*
K 072 Continued From page 1

use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits.
7.1.10

This STANDARD is not met as evidenced by:
Based on observation, it was determined that the facility failed to maintain egress from all furnishings.

The findings included:

1. Observations of the discharge path from the 100 corridor to to the public way on 12/19/11 at 9:20 AM, revealed a water hose and a charcoal grill in the path of egress.

2. Observations of the 5 foot wide service corridor exit on 12/19/11 at 10:00 AM, revealed 4 rolling food carts obstructing the egress path.

These findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 12/19/11.

NFPA 101 LIFE SAFETY CODE STANDARD

K 104 SS=0

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
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 104</td>
<td>Continued From page 2 facility failed to maintain smoke barriers. The findings included: Observations of the electrical mechanical room on the 200 corridor on 12/19/11 at 9:45 AM, revealed a penetration to the inside wall next to the door. This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 12/19/11.</td>
<td>K 104</td>
<td>K104 The facility will maintain smoke barriers. Corrective action: The hole in the electrical/mechanical room was repaired with one hour fire resistant material by the maintenance department on 12/19/2011. Rounds were made on 12/22/11 to identify any additional penetrations, none were found. Identification of the residents with potential to be affected: All residents have the potential to be affected by this practice. Measures/systemic changes put into place to ensure the deficient practice does not recur: Staff to be in-serviced on 1/13/12 on the importance of identifying and reporting penetrations to the maintenance department. Penetrations to be repaired immediately as identified. The maintenance department will make monthly facility rounds to identify any penetrations. How the corrective action will be monitored to ensure the deficient practice will not recur: Results of the monthly inspections of the facility by the maintenance department will be reported monthly to the Quality Assurance Committee for review and recommendations to ensure compliance with this regulation.</td>
<td>1/20/12</td>
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