STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	04/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(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
K010000	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: 04/22/14 Facility Number: 002982 Provider Number: 155700 AIM Number: 200382090 Surveyor: Mark Caraher, Life Safety Code Surveyor At this Life Safety Code survey, Catherine Kasper Home 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 two story facility with a basement was determined to be of Type II (000) construction and was fully sprinklered except for the main elevator machine room. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors	K010000	Please consider the Plan of Correction to be our credible allegation of compliance as of May 22, 2014 with the following exceptions: K056-a and K160. We have requested temporary waiver for completion of K056-a. and of K160 to occur within 6 months by October 22, 2014, in order to process capital funds and to obtain bids from professional contractors to complete the projects.	

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

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	and has hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 81 and had a census of 74 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the main elevator machine room. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/29/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010020 SS=E	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 8.2.5.6. 19.3.1.1. Based on observation and interview, the facility failed to ensure 2 of 3 vertical openings in the first floor communications room are enclosed with construction having a fire resistance rating of at least one hour. This deficient practice could affect 10 residents, staff	K010020	F 020 1) The 2 vertical openings identified in the floor of room 129 have been sealed with proper fire resistant caulk. 2) Other Maintenance Service	05/22/2014

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	and visitors in the vicinity of Room 129 if fire were to infiltrate the protective barriers. Findings include: Based on observation with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 2:20 p.m. on 04/22/14, two holes each measuring two inches in diameter for the passage of more than 50 cables were noted in the floor of Room 129 which served as the basement ceiling fire barrier of the room below. Based on interview at the time of observation, the Maintenance Manager acknowledged the aforementioned openings failed to maintain a fire resistance rating of at least one hour. 3.1-19(b)		rooms will be searched for any other vertical openings that may fail to maintain the fire resistant barrier. 3) Any other vertical openings identified will be filled with proper fire resistant caulk. The designated CKH Maintenance staff will complete inspection following any outside contractor work involving running of cables through vertical openings and will fill in holes with proper fire resistant caulk within 24-hours of completion on any such projects or repairs. Designated CKH Maintenance staff will sign off with initial and date, for any completion of new project or repair that involves creating any new vertical openings. 4) Document will be presented to CKLC Executive Director within 24-hours of completion or by the next business day. Any documents acquired will be presented to the QAA committee over the next 6 months, for review and for any further recommendations. QAA Committee will determine after 6 months if presentation of document to the committee continues to be necessary. 5) By May 22, 2014.	
K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾			

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	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 Based on observation and interview, the facility failed to ensure the door to 1 of 8 basement hazardous areas such as soiled linen rooms was provided with self closing devices to close and latch the door into the door frame. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the basement soiled linen storage room. Findings include: Based on observation with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 2:20 p.m. on 04/22/14, the corridor door nearest the elevator in the double door set to the basement soiled laundry storage room was not self closing. The aforementioned corridor door was equipped with a self closing device but was rendered inoperable by detaching the arm of the self closing device. The aforementioned room contained six mobile carts for	K010029	K 029 1) The self closing device of the door identified has been repaired. 2) All doors to hazardous areas in CKH will be audited to assure any required self closing devices are functioning properly. 3) Hazardous area door audits will be performed monthly to assure any self closing devices are functioning properly. Any devices discovered to not be functioning properly will be repaired or replaced at that time. 4) Door audits of hazardous areas will be performed monthly for the next 6 months by the Maintenance staff/designee and completion of audits will be verified by Executive Director. Results of audits will be presented to monthly QAA for review and for any further recommendations including determination of the need to	05/22/2014

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	soiled laundry storage. Based on interview at the time of observation, the Maintenance Manager acknowledged the aforementioned basement hazardous area access door was not equipped with a functional self closing device to close and latch the door into the door frame. 3.1-19(b)		continue the audits. 5) By 5-22-2014	
K010034 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 Based on observation and interview, the facility failed to ensure items stored in 1 of 5 interior fire escape stairways would not interfere with egress. LSC 7.2.2.5.3 requires usable space within an exit enclosure, including under stairs, or any open space within the enclosure shall not be used for any other purpose which could interfere with egress. This	K010034	K 034 1) All items identified have been removed from the A wing stairwell. 2) All stairwells in CKH have been audited for any items stored and items identified have been removed.	05/22/2014

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	deficient practice could affect 20 residents, staff and visitors using the A Wing stairwell for evacuation. Findings include: Based on observation with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 2:20 p.m. on 04/22/14, the first floor landing area of the A Wing stairwell was used to store two shelves, four portable food carts and a grocery shopping cart. Based on interview at the time of observation, the Maintenance Manager acknowledged the A Wing stairwell was used for storage which could interfere with egress. 3.1-19(b)		3) Management and Activity staff will be educated on requirement to keep stairwells free of storage and clutter and the importance of removing any items immediately. Residents at the May 7, 2014, Resident Council will be educated on importance of keeping stairwells free of storage. 4) Maintenance staff will perform weekly rounds of stairwells. Any negative results of audits will be verbally presented the following day to Department Managers at morning meeting M-F. Audit results will be summarized and presented to monthly QAA for 6 months to identify any trends and for any further recommendations including need for ongoing audits of stairwells. 5) By 5-22-2014.	
K010050 SS=C	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			

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	audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Log" documentation with the Maintenance Manager during record review from 9:40 a.m. to 11:30 a.m. on 04/22/14, second shift fire drills conducted on 08/29/13, 11/27/13 and 02/27/14 were conducted at, respectively, 2:45 p.m., 2:30 p.m. and 2:45 p.m. Based on interview at the time of record review, the Maintenance Manager acknowledged second shift fire drills were not conducted at unexpected times under varying conditions. 3.1-19(b)	K010050	K 050 1) Fire Drills will now be completed at various times during each shift during each quarter. 2) All residents could be affected by this practice. Fire Drills will now be completed at times that vary by at least an hour during each shift of each quarter. 3) A grid has been developed that will allow the Maintenance staff to plan the drills according to visual recognition that the upcoming time period will differ from the previous time period. 4) Upon evaluation of the Fire drill times will be verified by the Executive Director as varying by at least an hour from the drill conducted in the previous quarter. A summary the times of Fire Drills will be presented to the QAA committee for review and for any further recommendations. This will be ongoing. 5) By 5-22-2014.	05/22/2014
K010056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is			

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	installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 1. Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 2 elevator machine rooms. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon, or prior to, the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect two residents, staff and visitors. Findings include: Based on observation with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 2:20 p.m. on 04/22/14, the main elevator machine	K010056	K 056 1) a. The identified elevator room in the basement will be provided with automatic sprinkler coverage. (Temporary waiver to extend time up to 6 months to allow for correction has been requested). b. The identified armover to the sprinkler has been provided with the proper support. 2) a. The residents, staff or visitors who use the elevators have the potential to be affected. b. Staff or visitors to the Chiller room could be affected. 3) a. The elevator machine rooms will be assessed to be sure automatic sprinkler coverage is provided, if discovered not to be present, will be included in bids to provide required	10/22/2014

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	room in the basement was not provided with automatic sprinklers. Based on interview at the time of observation, the Maintenance Manager acknowledged comprehensive care residents have customary access to the main elevator and acknowledged the aforementioned elevator machine room was not provided with automatic sprinklers. 3.1-19(b) 3.1-19(ff) 2. Based on observation and interview, the facility failed to ensure the sprinkler system was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect 2 staff and visitors in the basement chiller room. Findings include: Based on observation with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 2:20 p.m. on 04/22/14, a 40 inch horizontal length of steel sprinkler pipe installed in the		coverage. b. Maintenance staff shall perform an audit of all steel sprinkler piping to determine if any exceed 24 inches horizontal length of unsupported armover to a sprinkler. Any armovers found to be non-compliance shall be corrected by 5-22-2014. 4) a. Automatic sprinkler coverage will be provided per regulation. Maintenance staff shall advise monthly QAA committee of progress of bids acquired and project completion dates to assure completion occurs per temporary waiver request within 6 months (by October 30, 2014). b. Maintenance Director shall provide a report to the QAA in June to describe any other armover corrections that had to be made by 5-22-2014 and any other concerns identified related to armover compliance issues. QAA committee will review information and provide any additional recommendations if any as well as any requirement to present any ongoing assessment information related to armover compliance. 5) a. Within 6 months from April 22, 2014. b. By 5-22-2014.	

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	basement chiller room was an unsupported armover to a sprinkler. Based on interview at the time of observation, the Maintenance Manager acknowledged the aforementioned sprinkler location was an unsupported armover greater than 24 inches in length for a steel pipe. 3.1-19(b) 3.1-19(ff)			
K010062 SS=C	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 and interview, the facility failed to document weekly fire pump inspection, testing and maintenance for 1 of 1 fire pumps for the most recent twelve month period. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition, Chapter 5-1.1 provides the minimum requirements for the routine inspection, testing, and maintenance of fire pump	K010062	F 062 1) a. The fire pump has been tested. b. The cables attached to the sprinkler pipe have been removed. 2) a. The fire pump inspection, testing and maintenance results have been made available for	05/22/2014

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	assemblies. Table 5-1.1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Chapter 5-3.2.1 requires a weekly test of electric motor driven pump assemblies shall be conducted without flowing water. This test shall be conducted by starting the pump automatically. The pump shall run a minimum of 10 minutes. Exception: A valve installed to open as a safety feature shall be permitted to discharge water. 5-3.2.2.1. The automatic weekly test timer shall be permitted to be substituted for the starting procedure. The pertinent visual observations specified in Chapters 5-2.2.1, through Chapter 5-2.2.3 shall be performed weekly. Chapter 1-8 states records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of Peerless Midwest Inc. "Fire Pump Test" documentation dated 11/07/13 with the Maintenance Manager during record review from 9:40 a.m. to 11:30 a.m. on 04/22/14, documentation		review to the authority having jurisdiction. b. Fire system sprinkler piping in CKH will be assessed to determine if any other cables are attached to the pipes. Any cables discovered to be attached will be removed prior to 5-22-2014. 3) a. Any fire pump inspection, testing and maintenance results will be available in a location accessible to the CKH Maintenance staff at all times. CKH Maintenance staff will monitor the completion of inspections, testing and maintenance of the fire pump to assure compliance. b. Any need for outside contractors providing new installation of cables or repairs involving cables will be coordinated with the CKH Maintenance staff to assure no cables are attached to Fire system sprinklers. 4) a. CKH Maintenance staff will review the Fire Pump inspection, testing and maintenance records weekly to assure proper compliance and verify with dates and initials of review. A report of compliance will be provided to the monthly QAA committee for 6 months for review and any recommendations including determination of need for any ongoing reports involving the fire	

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	of weekly fire pump inspection, testing and maintenance for the most recent twelve month period was not available for review. Only an annual test of the electric motor driven pump assembly was conducted as documented in the 11/07/13 inspection documentation. Based on interview at the time of observation, the Maintenance Manager stated he was unaware weekly fire pump inspection, testing and maintenance was required and acknowledged documentation of weekly fire pump inspection, testing and maintenance for the most recent twelve month period was not available for review. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was maintained in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. LSC 9.7.1 states all automatic sprinkler systems shall be maintained in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 states sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect 10 residents, staff and visitors in the vicinity of Room 129.		pump after 6 months of compliance. b. CKH Maintenance staff will provide report of any new cables discovered attached to sprinkler pipes to QAA for 6 months for review and for any recommendations including determination of need for any ongoing reports involving the cables and sprinkler pipes after 6 months of compliance. 5) a and b by 5-22-2014	

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	Findings include: Based on observation with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 2:20 p.m. on 04/22/14, a one foot section of two inch sprinkler pipe in Room 129 had more than 50 cables attached to the sprinkler pipe with two straps. Based on interview at the time of the observation, the Maintenance Manager acknowledged the aforementioned sprinkler pipe location had cables attached to the sprinkler pipe. 3.1-19(b)			
K010064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to inspect 2 of 36 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers,	K010064	K 064 1) All fire extinguishers have been inspected. 2) All fire extinguishers will be reviewed for proper inspection compliance. Any extinguishers discovered not to have been inspected will be	05/22/2014

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	Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect 17 residents, staff and visitors in the vicinity of Room 204 and Room 209. Findings include: Based on observations with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 2:20 p.m. on 04/22/14, the annual maintenance tag attached to each of two portable fire extinguishers in the corridor outside Room 204 and outside Room 209 indicated monthly inspections had not been documented for November and December 2013. Based on interview at the time of the observations, the Maintenance Manager stated no other monthly portable fire extinguisher inspection documentation was available		inspected at that time. 3) Maintenance staff will develop a list of all fire extinguishers in CKH that require inspection. The list will require Maintenance staff initial in addition to the card on the extinguisher to assure all extinguishers are inspected. 4) Completed Fire extinguisher list will be provided to Executive Director for review monthly prior to the QAA committee meeting. Results of the completed Fire extinguisher list will be presented to the monthly QAA committee for review and any further recommendations including need for ongoing reports to the QAA after 6 months of compliance. 5) By 5-22-2014	

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	155700	A. BUILDING 01 B. WING	04/22/2014

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	for review and acknowledged monthly inspections for the aforementioned portable fire extinguishers were not documented for November and December 2013. 3.1-19(b)			
K010067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully	K010067	K 067 1) The identified fire damper has been inspected and functions properly. 2) Fire damper inspection records will be reviewed by The Campus Maintenance Director for any dampers that may have been missed upon required 4 year inspections. Any dampers discovered to have missed inspections will be scheduled for inspections to occur before 5-22-2014. 3) Fire Damper inspection results	05/22/2014

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	close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice could affect 10 residents, staff and visitors in the vicinity of Room 129. Findings include: Based on record review with the Maintenance Manager from 9:40 a.m. to 11:30 a.m. on 04/22/14, documentation of fire damper inspection and maintenance performed at least every four years was not available for review. Based on observation with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 2:20 p.m. on 04/22/14, one fire damper was noted in the ductwork of the makeup air handling unit which penetrated the floor in Room 129. No documentation was affixed to the fire damper indicating the date of the most recent inspection and maintenance. Based on interview at the time of observation, the Maintenance Manager was unaware of any additional fire dampers located in the facility and acknowledged documentation of fire damper inspection and maintenance performed at least every four years was not available for review. 3.1-19(b)		will be performed at least every 4 years and will be available to the authorized jurisdiction for review upon request. Any dampers discovered to have been missed for proper inspections will be scheduled for inspections to occur at least every 4 years. 4) The Maintenance Director shall provide a report of the audits completed to the next QAA committee to assure damper inspections are now current. QAA committee will review and provide any further recommendations. Damper inspection results will be presented to the QAA committee ongoing as they occur at least every 4 years. 5) By 5-22-2014	

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K010154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period in order to protect 74 of 74 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could	K010154	K 154 1) The Fire Watch Policy has been updated and approved by the Administrative Leadership Council and the Executive Director to reflect the proper notification of the insurance carrier, alarm monitoring company and building owner. 2) All residents have the potential to be affected and the new policy and procedure is now in place. 3) The Policy and Procedure has been updated for notification of the correct entities in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24-hour period. The Maintenance staff and Executive Director have been	05/22/2014

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	affect all residents, staff and visitors. Findings include: Based on review of "Smoke/Fire Watches" documentation with the Maintenance Manager during record review from 9:40 a.m. to 11:30 a.m. on 04/22/14, the fire watch policy did not include notification of the insurance carrier, alarm monitoring company and building owner in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period. Based on interview at the time of record review, the Maintenance Manager stated no additional fire watch documentation was available for review and acknowledged the written fire watch policy did not include notification of the insurance carrier, alarm monitoring company and building owner in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period. 3.1-19(b) 3.1-19(ff)		educated to the updated Policy and procedure. 4) The Maintenance Director will provide a report of any events that involve placing the automatic sprinkler system out of service for more than 4 hours in a 24-hour period to the monthly QAA Committee in the event that any such event(s) had occurred during that month for any recommendations. This will be ongoing. 5) By 5-22-2014	
K010160 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel			

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	distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2 Based on observation and interview, the facility failed to ensure the elevator equipment in 2 of 2 elevator equipment rooms was provided with a shunt trip. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon, or prior to, the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect two residents, staff and visitors in the facility elevator and in the vicinity of the freight elevator if the sprinkler system was activated in either elevator machine room. Findings include: Based on observations with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 2:20 p.m. on 04/22/14, the following was noted: a. the main elevator machine room in the basement was not provided with automatic sprinklers and no evidence of shunt trip installation was noted.	K010160	K 160 1) Shunt trip installation will occur for both elevator machine rooms identified. (A waiver for at least 6 months (by October 22, 2014) has been requested due to the capital expense required to accomplish this installation) 2) Residents, staff and/or visitors on either of the identified elevators and in the vicinity of either elevator if the sprinkler system was activated in either elevator machine room, so the installation of the shunt trip will occur within the next 6 months. 3) All elevator machine rooms in CKH will be equipped with the proper shunt trip. 4) The Maintenance Director/Executive Director shall provide the QAA committee with a monthly update as to the capital approval and the corresponding scheduling progress for the installation of the shunt trip, until the project is completed. Upon completion of the project, the QAA committee will be advised for any further recommendations.	10/22/2014

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	b. the freight elevator machine room in the basement was provided with automatic sprinklers and no evidence of shunt trip installation was noted. Based on interview at the time of the observations, the Maintenance Manager acknowledged comprehensive care residents have customary access to the main elevator and acknowledged the aforementioned elevator machine rooms were not provided with a shunt trip. 3.1-19(b)		5) Within 6 months from April 22, 2014.	