DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BLDG 1, 2, 3, 4, 5 MILW C B. WING	(X3) DATE SURVEY COMPLETED
	524001		05/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILWAUKEE CTY BEHAVIORAL HLTH DIV	9455 W WATERTOWN PLANK RD MILWAUKEE, WI 53226

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K 000	INITIAL COMMENTS Surveyor: 22219 A standard Recertification Survey for Life Safety Code compliance was conducted by the Wisconsin Division of Quality Assurance on 05/11/2010. The Milwaukee County Behavior Health Center was found to be NOT in compliance with the following applicable regulations for hospital participation in Medicare-Medicaid: 42 CFR 482.41 Condition of Participation: Physical Environment was NOT MET 42 CFR 482.41(b) Standard: Safety from Fire was NOT MET NFPA 101- Life Safety Code was NOT MET (Chapter 19-Existing Health Care). The Milwaukee County Behavioral Health Center is a 4-story structure built in 1976, with Type 1 fire-resistive construction. This is not a traditional 4-story structure. The multi-story split-story facility was built on a number of hills. Wing #1 is a 1-Story, Wing #2 is 4-Story, Wing #3 is a 2-Story, Wing #4 is a 3-Story and Wing #5 is a 2-Story. All of these wings are considered one facility because they are not 2-hour separated except between floors. The 4th Floor of Wing #4 is a Nursing Home and was not included in this survey. All portions of the facility were sprinkled. The campus had an emergency generator that provided power to the emergency loads. The facility contained 17 patient care wings and 36 smoke compartments. Milwaukee County Behavioral Health Center is licensed for 144 beds, with a census of 120 inpatients at the time of the survey. The facility operated outpatient functions and also had 18 outpatients in the building on that day. The	K 000	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was correctly cited. This Plan of Correction is submitted to comply with State and Federal laws.	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: BHD Administrator — (X6) DATE: 6/14/10

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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K 000	Continued From page 1 facility was surveyed under the 2000 Life Safety Code, Chapter 19 for an existing health care occupancy. Federal deficiencies of the Life Safety Code were cited.	K 000		
K 012	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	K 012		
	This STANDARD is not met as evidenced by: Surveyor: 18107 Based on observation and interview, the facility did not provide and maintain the required building construction type that had support steel covered with rated fire proofing, and sealed floor penetrations. This deficiency occurred in 4 of the 36 smoke compartments, and would affect 35 of the 120 patients in the facility on the day of the survey, as well as staff and visitors.		**K012** The hospital will be constructed, arranged and maintained to ensure the safety of all patients, staff and visitors. The facility will provide a safe, clean and properly maintained environment in compliance with NFPA 101-Life Safety Codes (See A 701, A 726 and the K tags).	
	FINDINGS INCLUDE: 1. On May 6, 2010 at 11:30 am surveyor #18107 observed in the 42-B smoke compartment on the 2nd floor that in the Maintenance Area fire proofing was missing from the structural steel at the ceiling. This observed situation was not compliant with NFPA 101 (2000 edition), 19.1.6.2. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		1. The exposed structural steel will be recoated with fireproofing by an authorized fireproofing contractor. This work requires retaining a qualified contractor in addition to planning and design requirements. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Enginee	10/1/10
	2. On May 4, 2010 at 9:00 am surveyor #18107 observed in the 32-D1 smoke compartment on the 2nd floor that in the Treatment Room there		2. Caulk with appropriate UL design standard fire retardant material penetrations in the floor of the Treatment Room, located on Unit 32-D1.	6/25/10

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K 012	Continued From page 2 were penetration(s) through the floor that were not fire stopped according to a UL design standard. The deficiency included an open hole in the floor. Penetrations adversely affected the ability of the building to compartmentalize fires to a single floor. This observed situation was not compliant with NFPA 101 (2000 edition), 19.1.6 and 8.2.3.2.4.2. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.), and Staff C (Crisis Dir.) .	K 012	Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Engineer	
	3. On May 4, 2010 at 2:13 pm surveyor #18107 observed in the 32-A1 smoke compartment on the 2nd floor that in the #23-Electrical Closet there were penetration(s) through the floor that were not fire stopped according to a UL design standard. The deficiency included a non-sealed sleeve. Penetrations adversely affected the ability of the building to compartmentalize fires to a single floor. This observed situation was not compliant with NFPA 101 (2000 edition), 19.1.6 and 8.2.3.2.4.2. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .		3. Caulk with appropriate UL design standard fire retardant material penetrations in the floor of Room #23-Electrical Closet, located on Unit 32-A1. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Engineer 6/25/2010	6/25/10
	4. On May 6, 2010 at 11:40 am surveyor #18107 observed in the 42-B smoke compartment on the 2nd floor that in the Maintenance Toilet Room there were penetration(s) through the floor that were not fire stopped according to a UL design standard. The deficiency included four (4) floor penetrations near the sink, urinal and lavatory. Penetrations adversely affected the ability of the building to compartmentalize fires to a single floor. This observed situation was not compliant with NFPA 101 (2000 edition), 19.1.6 and		4. Caulk with appropriate UL design standard fire retardant material penetrations on the floor of the Maintenance Toilet Room on Unit 42-B, located near the sink, urinal and lavatory. Responsible Person: [redacted] Director of Operations, [redacted], Mech. Utilities Engineer	6/25/10

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K 012	Continued From page 3 8.2.3.2.4.2. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) . 5. On May 6, 2010 at 4:34 pm surveyor #18107 observed in the 21-N smoke compartment on the 1st floor that in the #1025-Room there were penetration(s) through the floor that were not fire stopped according to a UL design standard. The deficiency included electrical conduit. Penetrations adversely affected the ability of the building to compartmentalize fires to a single floor. This observed situation was not compliant with NFPA 101 (2000 edition), 19.1.6 and 8.2.3.2.4.2. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .	K 012	5. Caulk with appropriate UL design standard fire retardant material the penetrations found in Room #1025. The need to inspect for missing fire caulk and fire proofing will be included as an item for annual environmental inspections as well as part of annual damper safety inspections Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Engineer	6/25/10
K 017	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017		

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K 017	Continued From page 4	K 017		
	This STANDARD is not met as evidenced by: Surveyor: 22219 Based on observation and interview, the facility did not provide and maintain wall construction to protect the corridor from non-corridor spaces that had a smoke-tight corridor ceiling (in a sprinkled smoke zone), and sealed wall penetrations. This deficiency occurred in 2 of the 36 smoke compartments, and would affect 20 of the 120 patients in the facility on the day of the survey, as well as staff and visitors.			
	FINDINGS INCLUDE: 1. On May 6, 2010 at 8:39 am surveyor #18107 observed in the 43-H1 smoke compartment on the 3rd floor that in the Corridor at Smoke Barrier the corridor separation construction did not resist the passage of smoke because of one or more unsealed holes. The holes included an access panel that was missing in the ceiling. Corridors in sprinkled smoke compartments can have either walls or ceiling with construction that resists the passage of smoke. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.6.2.1. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .		**K017** 1. Seal all holes, including a missing access panel in the ceiling, in the Corridor at the Smoke Barrier of the 3rd floor in Unit 43-H1 Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Engineer	6/25/10
	2. On May 3, 2010 at 2:50 pm surveyor #18107 observed in the 52-A1 smoke compartment on the 2nd floor that in the Corridor, penetration(s) were not sealed according to approved UL designs. The corridor was not within a fully-sprinkled smoke compartment and the separation wall was required to have a 30 minute		2. The corridor penetrations, including the rock wool sprinkler pip will be fire caulked by 6/25/2010. There is a duct to be enclosed that is scheduled to be completed by 8/1/2010. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Engineer	6/25/10 8/1/10

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K 017	Continued From page 5 fire resistance rating, including all penetrations. Penetrations included a sprinkler pipe with rock wool backing but no fire-rated sealant. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.6.2.2. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .	K 017		
	3. On May 6, 2010 at 8:41 am surveyor #18107 observed in the 43-H1 smoke compartment on the 3rd floor that in the Corridor at Smoke Barrier, penetration(s) were not sealed according to approved UL designs. The corridor was not within a fully-sprinkled smoke compartment and the separation wall was required to have a 30 minute fire resistance rating, including all penetrations. Penetrations included an unsealed sleeve with cabling. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.6.2.2. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .		3. Seal the penetrations with appropriate UL design material in the Corridor at the Smoke Barrier, including an unsealed sleeve of cabling, to ensure a 30 minute fire resistance rating, on the 3rd floor corridor on Unit 43-H1. Responsible Person: [redacted] Director of Operations, [redacted], Mech. Utilities Engineer	6/25/10
	4. On May 6, 2010 at 8:47 am surveyor #18107 observed in the 43-H1 smoke compartment on the 3rd floor that in the Corridor by Smoke Barrier, penetration(s) were not sealed according to approved UL designs. The corridor was not within a fully-sprinkled smoke compartment and the separation wall was required to have a 30 minute fire resistance rating, including all penetrations. Penetrations included an unsealed sleeve with cabling. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.6.2.2. The deficiency was confirmed at the time of discovery by a concurrent observation and		4. Seal the penetrations with appropriate UL design material in the Corridor at the Smoke Barrier, including an unsealed sleeve of cabling, to ensure a 30 minute fire resistance rating, on the 3rd floor corridor on Unit 43-H1. Responsible Person: [redacted] Director of Operations, [redacted], Mech. Utilities Engineer	6/25/10

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K 017	Continued From page 6 interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .	K 017		
K 018	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ 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: Surveyor: 22219 Based on observation and interview, the facility did not provide corridor separation doors that had positive-latching dutch doors, doors with positive-latching hardware, and doors that would close when pushed or pulled. This deficiency occurred in 5 of the 36 smoke compartments, and would affect 50 of the 120 patients in the facility on the day of the survey, as well as staff and visitors.	K 018	**K018** see page 8	

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K 018	Continued From page 7 FINDINGS INCLUDE: 1. On May 4, 2010 at 8:42 am surveyor #18107 observed in the 32-D1 smoke compartment on the 2nd floor that in the #2013-Intake Foyer the door to the corridor was split in the middle to form a "dutch door". The upper door would not positively self-latch to the bottom door or the frame. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.6.3.6. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.), and Staff C (Crisis Dir.) .	K 018	1. The Dutch door between the intake foyer and the security office will have the two sections sealed together so the door is a solid one piece door. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv.	6/25/10
	2. On May 4, 2010 at 9:30 am surveyor #18107 observed in the 32-D1 smoke compartment on the 2nd floor that in the 2124-Office the door to the corridor was split in the middle to form a "dutch door". The upper door would not positively self-latch to the bottom door or the frame. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.6.3.6. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.), and Staff C (Crisis Dir.) .		2. The half door at Room #2124 will have the deadbolt latch replaced with a lever handle latch. The lever handle hardware is to be ordered with delivery and installation to be completed by 8/1/2010. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv.	8/1/10
	3. On May 4, 2010 at 9:45 am surveyor #18107 observed in the 32-D1 smoke compartment on the 2nd floor that in the #2112-Police Report Room the door to the corridor was split in the middle to form a "dutch door". The upper door would not positively self-latch to the bottom door or the frame. The door had a manual dead bolt. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.6.3.6. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.&		3. The 2112 police room Dutch door will have the two sections sealed together so the door is a solid one piece door. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv.	6/25/10

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K 018	Continued From page 8 Maint.Sprvsr.), and Staff C (Crisis Dir.) .	K 018		
	4. On May 7, 2010 at 10:36 am surveyor #18107 observed in the 31-A smoke compartment on the 1st floor that in the #1007-Mail Room the door to the corridor was split in the middle to form a "dutch door". The upper door would not positively self-latch to the bottom door or the frame. The upper door had a deadbolt that did not positively self-latch. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.6.3.6. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .		4. The 1007 half door will have the deadbolt latch replaced with a lever handle latch. The lever handle hardware is to be ordered with delivery and installation scheduled to be completed by 8/1/2010. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv.	8/1/10
	5. On May 7, 2010 at 1:48 pm surveyor #18107 observed in the 31-B smoke compartment on the 1st floor that in the #1095-Office and Main Court Room the door to the corridor was split in the middle to form a "dutch door". The upper door would not positively self-latch to the bottom door or the frame. The upper door had a deadbolt that did not positively self-latch. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.6.3.6. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .		5. The 1095 door will have the deadbolt latch replaced with a lever handle latch. The lever handle hardware is to be ordered with delivery and installation scheduled to be completed by 8/1/2010. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv.	8/1/10
	6. On May 3, 2010 at 2:25 pm surveyor #18107 observed in the 52-A1 smoke compartment on the 2nd floor that in the #2329-Dishwashing Room the corridor door would not remain fully-closed if a force of 5 lbs were applied to the latch edge of the door. Positive latching was not possible because of mis-alignment. This observed situation was not compliant with NFPA		6. The 52-A Room#2320 dish room doors require replacement. A quote for replacement doors has been received. This is a budget item requiring funds to be approved before ordering. The ordering and receipt of these doors is expected to take 10 weeks with installation scheduled to be completed by 10/1	10/1/10

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K 018	Continued From page 9 101 (2000 edition), 19.3.6.3.2. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .	K 018	Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv.	
	7. On May 7, 2010 at 11:55 am surveyor #18107 observed in the 31-B smoke compartment on the 1st floor that in the #1084-Storage Room the door to the corridor was held open with a a door chuck. The door would not release with a push or pull. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.6.3.3. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .		7. Remove the door chuck that had propped open the door to Room #1084-Storage Room, located in 31-B, so that the door will release with a push or pull. In addition, all staff will be instructed that the use of door chucks is prohibited. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv.	6/25/10
	8. On May 11, 2010 at 9:18 am surveyor #18107 observed in the 42-A2 smoke compartment on the 2nd floor that in the #2208-Central Supply Room (Hardware Rm.) the door to the corridor was held open with a a patient lift. The door would not release with a push or pull. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.6.3.3. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .		8. Remove the patient lift that had propped open the door to Room #2208-Central Supply (Hardware Room), located in 42-A2, so that the door will release with a push or pull. In addition, all staff will be instructed that doors should not be propped open. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv.	6/25/10
	9. On May 11, 2010 at 2:30 pm surveyor #18107 observed in the 53-A1 smoke compartment on the 3rd floor that in the #23-Pantry the door to the corridor was held open with a food cart. There was a closer on the door. The door would not release with a push or pull. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.6.3.3. The deficiency was confirmed		9. Remove the food cart that had propped open the door to Room #23-Pantry, located on Unit 53-A1, so that the door will release with a push or pull. In addition, all staff will be instructed that doors should not be propped open. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv.	6/25/10

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(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
K 018	Continued From page 10 at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .	K 018		
K 025	NFPA 101 LIFE SAFETY CODE STANDARD 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: Surveyor: 22219 Based on observation and interview, the facility did not provide and maintain the fire-rating and smoke tightness of smoke barrier walls that had sealed wall penetrations and rated wall construction. This deficiency occurred in 20 of the 36 smoke compartments, and would affect 90 of the 120 patients in the facility on the day of the survey, as well as staff and visitors. FINDINGS INCLUDE: 1. On May 3, 2010 at 2:16 pm surveyor #18107 observed in the 52-B smoke compartment on the 2nd floor that in the #2301-Food Service penetration(s) were not sealed according to approved UL designs. The deficiency included an opening at the top of the wall above a 48"x 20"	K 025	**K025** 1. Seal according to approved UL design the penetrations inRoom #2301-Food Service, located in 52-B, including an opening at the top of the wall above a 48"x20" mechanical duct. Responsible Person: [redacted] Director of Operations, Mech. Utilities Engineer	6/25/10

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K 025	Continued From page 11 mechanical duct. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.7.3. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .	K 025		
	2. On May 4, 2010 at 3:26 pm surveyor #18107 observed in the 53-B1 smoke compartment on the 3rd floor that in the #13-Conference Room penetration(s) were not sealed according to approved UL designs. The deficiency included various penetrations. The smoke barrier wall was not fire-rated because the top of wall at the deck was not sealed and screws were not fully-covered with joint compound. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.7.3. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .		2. Seal according to approved UL design the penetrations in Room#13-Conference Room, located in 53-B1, including the top of the wall at the deck and where screws are not fully-covered with joint compound. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Engineer	6/25/10
	3. On May 5, 2010 at 2:04 pm surveyor #18107 observed in the 53-A1 smoke compartment on the 3rd floor that in the Corridor at Smoke Barrier penetration(s) were not sealed according to approved UL designs. The deficiency included multiple pipes. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.7.3. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .		3. Seal according to approved UL design the penetrations in the Corridor at the Smoke Barrier, located on Unit 53-A1, including multiple pipes. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Engineer 6/25/2010	6/25/10
	4. On May 6, 2010 at 11:46 am surveyor #18107 observed in the 42-B smoke compartment on the 2nd floor that in the 2220-Corridor by Smoke Barrier penetration(s) were not sealed according to approved UL designs. The deficiency included		4. The penetrations at the Room#2220 corridor smoke barrier door will require the ductwork to be removed to provide access to the area above the ductwork. This will require planning, designing and budget approval along with coordination with various contractors. This work will be completed by 11/1.	11/1/10

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K 025	Continued From page 12 multiple ducts, sleeves, and pipes. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.7.3. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .	K 025	Responsible Person: [redacted] Director of Operations, Mech. Utilities Engineer	
	5. On May 3, 2010 at 2:10 pm surveyor #18107 observed in the 52-A1 smoke compartment on the 2nd floor that in the #2314-Staff CC's Office the smoke barrier wall was not constructed to a 30 minute fire resistance rating because the uppermost 6" of wall was missing. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.7.3. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .		5. Replace the uppermost 6" of wall that is missing to create a 30 minute fire resistance rating in Room #2214-Staff CC's Office, located on 52-A1. Responsible Person: [redacted] Director of Operations, Mech. Utilities Engineer	6/25/10
	6. On May 3, 2010 at 2:20 pm surveyor #18107 observed in the 52-A1 smoke compartment on the 2nd floor that in the Corridor the smoke barrier wall was not constructed to a 30 minute fire resistance rating because the top of wall was not sealed at the deck above. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.7.3. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .		6. Seal the top of the wall to the deck above in the corridor at the smoke barrier wall on the 2nd floor in 52-A1 so that it is a 30 minute fire resistance rating. Responsible Person: [redacted] Director of Operations, Mech. Utilities Engineer	6/25/10
	7. On May 3, 2010 at 2:50 pm surveyor #18107 observed in the 52-A2 smoke compartment on the 2nd floor that in the 52A Corridor the smoke barrier wall was not constructed to a 30 minute fire resistance rating because the top of wall and		7. Seal the top of the wall and both sides of the dry wall where they meet the adjacent concrete block wall to create a 30-minute fire resistance rating on the 2nd floor in the 52A Corridor at the smoke barrier wall. Responsible Person: [redacted] Director of Operations, Mech. Utilities Engineer	6/25/10

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K 025	Continued From page 13 both sides of the drywall wall were not sealed where they met the adjacent concrete block wall. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.7.3. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .	K 025		
	8. On May 4, 2010 at 8:58 am surveyor #18107 observed in the 32-C1 smoke compartment on the 2nd floor that in the Corridor by Smoke Barrier, the smoke barrier wall was not constructed to a 30 minute fire resistance rating because screws were not covered with joint compound and the wall was not enclosed at the top of two (2) mechanical ducts. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.7.3. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.), and Staff C (Crisis Dir.) .		8. The penetrations at the 32-C smoke barrier door will require the ductwork to be removed to provide access to the area above the ductwork. This will require planning, designing and budget approval along with coordination with various contractors. This work will be completed by 11/1/2010. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Engineer	11/1/10
	9. On May 4, 2010 at 2:58 pm surveyor #18107 observed in the 53-B1 smoke compartment on the 3rd floor that in the Corridor at Smoke Barrier the smoke barrier wall was not constructed to a 30 minute fire resistance rating because the top of the wall at the deck above was not sealed. The vertical side joints and joint against door frame header were not sealed. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.7.3. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .		9. The penetrations at the 53-B corridor smoke barrier wall at the smoke doors will require that the ductwork be removed to provide access to the area above the ductwork. This will require planning, designing and budget approval along with coordination with various contractors. This work will be completed by 11/1/2010 Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Engineer	11/1/10

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K 025	Continued From page 14 10. On May 6, 2010 at 11:10 am surveyor #18107 observed in the 43-F1 smoke compartment on the 3rd floor that in the Corridor by Smoke Barrier the smoke barrier wall was not constructed to a 30 minute fire resistance rating because seams in the drywall were not taped and multiple screws were not covered with joint compound. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.7.3. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .	K 025	10. Seal the seams of the drywall and cover multiple screws with joint compound to create a 30 minute fire resistance rating on the 3rd floor Corridor by Smoke Barrier, located on Unit 43-F1. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Engineer	8/1/10
	11. On May 7, 2010 at 2:21 pm surveyor #18107 observed in the 31-B smoke compartment on the 1st floor that in the Old Library Room the smoke barrier wall was not constructed to a 30 minute fire resistance rating because the wall contained un-rated glass in the walls and door. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.7.3. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .		11. The old library area will have the unrated glass doors replaced with ¾ hour rated doors. These doors will also require ADA automatic opening coordinated with proper latching. This is also part of enclosing the room as hazardous space, which will require proper design and coordination with updates to the fire evacuation plans as part of tag K029. Obtaining budget approval, retaining a consultant, developing design, plan reviews and construction of this work will be completed by 3/1/2011.	3/1/11
K 027	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	K 027	The Milwaukee County Behavioral Health Division will continue to inspect smoke barriers to include the following: Identifying penetrations or exposed screws and seams, etc. Identifying any penetrations at ductwork along with providing the planning, design, and contractor coordination to remove ductwork and properly seal any such openings Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Engineer	

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K 027	Continued From page 15	K 027		
	This STANDARD is not met as evidenced by: Surveyor: 22219 Based on observation and interview, the facility did not provide and maintain smoke barrier door assemblies that meet code requirements for separation of smoke compartments that had smoke-tight seals at meeting edges, and closers on all doors. This deficiency occurred in 6 of the 36 smoke compartments, and would affect 50 of the 120 patients in the facility on the day of the survey, as well as staff and visitors. FINDINGS INCLUDE: 1. On May 4, 2010 at 9:46 am surveyor #18107 observed in the 32-D1 smoke compartment on the 2nd floor that in the Corridor at Smoke Barrier the room had double smoke barrier doors with a gap greater than 1/8" at their meeting edges that was not sealed with an astragal to resist the passage of smoke. The doors were warped. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.7.6 and 8.3.4. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.), and Staff C (Crisis Dir.) . 2. On May 5, 2010 at 3:26 pm surveyor #18107 observed in the 53-C smoke compartment on the 3rd floor that in the #3308-Smoke Barrier Corridor Doors the room had double smoke barrier doors with a gap greater than 1/8" at their meeting edges that was not sealed with an astragal to resist the passage of smoke. This observed situation was not compliant with NFPA 101 (2000		**K027** 1. The 32-D corridor smoke doors will require replacement. Due to the special size and construction for these doors, budget approval will need to be obtained, along with ordering and expected extended delivery time. This work will be completed by 10/1/2010. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Engineer 2. The 53-C #3308 corridor smoke doors will require replacement. Due to the special size and construction for these doors, budget approval will need to be obtained, along with ordering and expected extended delivery time. This work will be completed by 10/1/2010. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Engineer	10/1/10 10/1/10

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K 027	Continued From page 16 edition), 19.3.7.6 and 8.3.4. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .	K 027		
	3. On May 6, 2010 at 8:35 am surveyor #18107 observed in the 43-H1 smoke compartment on the 3rd floor that in the #3-04-Corridor near Women's Toilet the room had double smoke barrier doors with a gap greater than 1/8" at their meeting edges that was not sealed with an astragal to resist the passage of smoke. The astragal on the door was damaged and was unable to provide a seal that resisted the passage of smoke. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.7.6 and 8.3.4. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .		3. Replace the damaged astragal on the doors in the #3-04-Corridor near the Women's Toilet, located on Unit 43-H1, to resist the passage of smoke when doors are closed. Responsible Person: [redacted] Director of Operations, [redacted], Mech. Utilities Engineer	6/25/10
	4. On May 4, 2010 at 3:38 pm surveyor #18107 observed in the 53-B1 smoke compartment on the 3rd floor that in the Corridor at Smoke Barrier the smoke barrier door would not self-close because the door was broken. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.7.6 . The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .		4. Repair the mechanism that self-closes the doors on the 3rd floor in the Corridor at Smoke Barrier, located on Unit 53-B1. Responsible Person: [redacted] Director of Operations, [redacted], Mech. Utilities Engineer	6/25/10
K 029	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 029	**K029** General: The Milwaukee County Behavioral Health Division plans to retain a consultant to determine which rooms are to be identified as hazardous and for storage. The fire evacuation plans will be updated to reflect this identification as well as plan for updating the designated areas to comply with NFPA codes,	4/1/10

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K 029	Continued From page 17 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 029	including wall construction and door construction/replacements. It is expected that this process, including obtaining the funding approval will be completed by April 1, 2011. 04/1/2010	
	This STANDARD is not met as evidenced by: Surveyor: 18107 Based on observation and interview, the facility did not enclose hazardous rooms with closers on all doors, rated doors, doors with positive-latching hardware, and sealed wall penetrations. This deficiency occurred in 9 of the 36 smoke compartments, and would affect 70 of the 120 patients in the facility on the day of the survey, as well as staff and visitors.		The following will be done as immediate corrections:	
	FINDINGS INCLUDE: 1. On May 4, 2010 at 9:29 am surveyor #18107 observed in the 32-D1 smoke compartment on the 2nd floor that in the Electrical Closet the door would not self-close because there was no closer. This room was used for the storage of oxygen. The room was considered hazardous because it exceeded 50 sq. ft. and contained a quantity of stored combustible materials considered hazardous. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.2.1 and 8.4.1. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.), and Staff C (Crisis Dir.) .		1. 32-D electric closet: install door closer Responsible Person: [redacted] Director of Operations, Mech. Maintenance Superint. 7/15/2010	7/25/10

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K 029	Continued From page 18 2. On May 4, 2010 at 1:41 pm surveyor #18107 observed in the 32-A1 smoke compartment on the 2nd floor that in the #5-Tub Room the door would not self-close because there was no closer. This room was used for storage. The room was considered hazardous because it exceeded 50 sq. ft. and contained a quantity of stored combustible materials considered hazardous. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.2.1 and 8.4.1. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.) .	K 029	2. 32-A Tub room: install door closer Responsible Person: [redacted] Director of Operations, [redacted] Mech. Maintenance Superint.	7/15/10
	3. On May 4, 2010 at 1:44 pm surveyor #18107 observed in the 32-A1 smoke compartment on the 2nd floor that in the #6-Office the door would not self-close because there was no closer. This room was used for storage. The room was considered hazardous because it exceeded 50 sq. ft. and contained a quantity of stored combustible materials considered hazardous. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.2.1 and 8.4.1. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		3. 32-A #6: remove storage from Dr. Berlin's office Responsible Person" [redacted] Director of Operations, [redacted] Mech. Maintenance Superint.	6/25/10
	4. On May 4, 2010 at 1:48 pm surveyor #18107 observed in the 32-A1 smoke compartment on the 2nd floor that in the #41-Storage the door would not self-close because there was no closer. This room was used for storage. The room was considered hazardous because it exceeded 50 sq. ft. and contained a quantity of stored combustible materials considered hazardous. This observed situation was not compliant with		4. 32-A #41: install door closer Responsible Person: [redacted] Director of Operations, [redacted] Mech. Maintenance Superint.	7/15/10

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K 029	Continued From page 19 NFPA 101 (2000 edition), 19.3.2.1 and 8.4.1. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 029		
	5. On May 4, 2010 at 1:49 pm surveyor #18107 observed in the 32-A1 smoke compartment on the 2nd floor that in the #11-Storage the door would not self-close because there was no closer. This room was used for storage. The room was considered hazardous because it exceeded 50 sq. ft. and contained a quantity of stored combustible materials considered hazardous. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.2.1 and 8.4.1. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		5. 32-A #11: install door closer . Responsible Person: [redacted] Director of Operations, [redacted] Mech. Maintenance Superint.	7/15/10
	6. On May 4, 2010 at 2:01 pm surveyor #18107 observed in the 32-A1 smoke compartment on the 2nd floor that in the #34-Office and #29-Office the doors would not self-close because there were no door closers. This rooms were used for storage. The rooms were considered hazardous because they exceeded 50 sq. ft. and contained a quantity of stored combustible materials considered hazardous. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.2.1 and 8.4.1. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		6. 32-A #34, #29: install door closer Responsible Person: [redacted] Director of Operations, [redacted] Mech. Maintenance Superint.	7/15/10
	7. On May 7, 2010 at 11:05 am surveyor #18107 observed in the 31-A smoke compartment on the		7. 31-A 1039-1: install door closer; relocate recycle bins so they are separated from each other.	7/15/10

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K 029	Continued From page 20 1st floor that in the #1039-1-Storage Room the door would not self-close because there was no closing device on the door. The door was not labeled. The wall was not constructed to a 1-hour fire resistance rating. The room was used to store two (2) large 90 gallon paper storage bins. The room was considered hazardous because it exceeded 50 sq. ft. and contained a quantity of stored combustible materials considered hazardous. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.2.1 and 8.4.1. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 029	Responsible Person: [redacted], Director of Operations, [redacted]. Mech. Maintenance Superint.	
	8. On May 7, 2010 at 11:25 am surveyor #18107 observed in the 31-A smoke compartment on the 1st floor that in the #1045-Storage Room the door would not self-close because the door was not provided with a closing device. The door did not have a label to confirm its rating. The walls were not 1-hour rated. The same deficiency was observed in #1050-Storage Room and #1048-Storage Room. The room was considered hazardous because it exceeded 50 sq ft and contained a quantity of stored combustible materials considered hazardous. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.2.1 and 8.4.1. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		8. 31-A #1045, #1050, #1048: Install door closers. Responsible Person: [redacted], Director of Operations, [redacted]. Mech. Maintenance Superint.	7/15/10
	9. On May 7, 2010 at 2:01 pm surveyor #18107 observed in the 31-B smoke compartment on the 1st floor that in the #1116-Storage Room and #1122-Medical Records Room the doors would		9. 31B #1116, #1122: Replace doors and frames with ¾ hour rated doors and install door closers. Responsible Person: [redacted], Director of Operations, [redacted]. Mech. Maintenance Superint.	8/1/10

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K 029	Continued From page 21 not self-close because the closing devices were missing. The rooms were considered hazardous because they exceeded 50 sq. ft. and contained a quantity of stored combustible materials considered hazardous. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.2.1 and 8.4.1. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 029		
	10. On May 7, 2010 at 11:55 am surveyor #18107 observed in the 31-B smoke compartment on the 1st floor that in the #1084-Storage Room the room was not sprinkled and the fire barrier door could not be verified to have the required rating. Two (2) walls were not constructed to a 1-hour fire rating. The room was considered hazardous because it exceeded 50 sq. ft. and contained a quantity of stored combustible materials considered hazardous. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.2.1. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		10. 31-B #1084: Fire caulk 2 remaining walls, install ¾ hour door. Responsible Person: [redacted], Director of Operations, [redacted], Mech. Utilities Engineer	8/1/10
	11. On May 3, 2010 at 3:11 pm surveyor #18107 observed in the 52-A1 smoke compartment on the 2nd floor that in the #2330-Storage Room the door would not positively self-latch when released because of mis-alignment. This observed situation was not compliant with NFPA 101 (2000 edition), 8.2.3.2. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		11. 52-A 2330: adjust the door so it will positive latch when closed Responsible Person: [redacted], Director of Operations, [redacted], Operations & Maint. Supv	6/25/10

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K 029	Continued From page 22 12. On May 3, 2010 at 3:13 pm surveyor #18107 observed in the 52-A2 smoke compartment on the 2nd floor that in the #2337-Storage Room near loading dock the door would not positively self-latch when released because the doors were binding. This observed situation was not compliant with NFPA 101 (2000 edition), 8.2.3.2. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 029	12. 52-A 2337: the fire plan will be changed so this door is not required. Responsible Person: [redacted], Director of Operations, [redacted], Operations & Maint. Supv	6/25/10
	13. On May 3, 2010 at 3:35 pm surveyor #18107 observed in the 52-B smoke compartment on the 2nd floor that in the #2319-Materials Management Storeroom the door would not positively self-latch when released because of mis-alignment due to damage. This observed situation was not compliant with NFPA 101 (2000 edition), 8.2.3.2. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		13. 53-B 2319: adjust the door and coordinator so the door positive latches when closed. Responsible Person: [redacted], Director of Operations, [redacted], Operations & Maint. Supv	6/25/10
	14. On May 4, 2010 at 8:39 am surveyor #18107 observed in the 32-D1 smoke compartment on the 2nd floor that in the #2006-Storage Room the door would not positively self-latch when released because of mis-alignment. This observed situation was not compliant with NFPA 101 (2000 edition), 8.2.3.2. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.), and Staff C (Crisis Dir.).		14. 32-D 2006: adjust the closet door so it will positively latch when closed. Responsible Person: [redacted] Director of Operations, [redacted], Operations & Maint. Supv	6/25/10
	15. On May 3, 2010 at 12:00 pm surveyor #18107 observed in the 52-B smoke compartment on the 2nd floor that in the #2312-Housekeeping Storage		15. Remove a 3"x8" piece of wood that is embedded in the top of the wall within Room #2312, located in 52-B and then seal the area with approved UL design material	6/25/10

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K 029	Continued From page 23 Room penetration(s) were not sealed according to approved UL designs. The deficiency included a 3"x 8" piece of wood embedded in the top of the wall. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.2.5. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 029	Responsible Person: [redacted], Director of Operations, [redacted], Operations & Maint. Supv	
	16. On May 3, 2010 at 3:10 pm surveyor #18107 observed in the 52-A1 smoke compartment on the 2nd floor that in the #2329-Housekeeping Storage Room penetration(s) were not sealed according to approved UL designs. The deficiency included two (3'x 18", 24"x 12") ducts at two (2) walls. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.2.5. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		16. 52-A 2329: install drywall to enclose exposed ductwork. Responsible Person: [redacted] Director of Operations, [redacted], Mech. Utilities Engineer	7/25/10
	17. On May 11, 2010 at 9:34 am surveyor #18107 observed in the 42-A2 smoke compartment on the 2nd floor that in the #2208-Central Supply Room (Hardware Rm.) penetration(s) were not sealed according to approved UL designs. The deficiency included a minimum of eight (8) penetrations observed in one of the 1-hour fire-rated walls. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.2.5. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		17. 42-A 2208: fire caulk pipe penetrations Responsible Person: [redacted] Director of Operations, [redacted], Mech. Utilities Engineer	6/25/10
	18. On May 11, 2010 at 11:38 am surveyor #18107 observed in the 52-B1 smoke		18. 52-B #2307A, #2311: This will require consultation, planning, design, plan review to develop the proper solution to the duct straddling the corridor wall, with an expected completion date of April 1, 2011.	4/1/11

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K 029	Continued From page 24 compartment on the 2nd floor that in the #2307A & #2311- Patient Storage Room the enclosing wall was not constructed to a 1-hour fire resistance rating. The room was not sprinkled. The wall had a duct penetration that was not sealed and fire caulked through the 1-hour concrete block wall assembly. The room was used to store patient clothing and shelves were filled from 4 inches above the floor to at least 8 feet above the floor. The room was considered hazardous because it exceeded 100 sq ft and contained a quantity of stored combustible materials considered hazardous. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.2.5. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 029	Responsible Person: [redacted], Director of Operations, [redacted], Mech. Utilities Engineer Future MCBHD regular inspections will include inspecting for excess storage in rooms not designated for storage or as hazardous, with appropriate corrective actions to follow.	
K 033	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 22219 Based on observation and interview, the facility did not provide enclosures around exit stairs that were free of storage. This deficiency occurred in 2 of the 36 smoke compartments, and would affect 20 of the 120 patients in the facility on the	K 033		

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K 033	Continued From page 25 day of the survey, as well as staff and visitors. FINDINGS INCLUDE: 1. On May 4, 2010 at 1:40 pm surveyor #18107 observed in the 32-A1 smoke compartment on the 2nd floor that in the Stairwell #3-1 the stairwell was used for storage. Storage included a wood pallet at the bottom of the steps. This observed situation was not compliant with NFPA 101 (2000 edition), 7.1.3.2.3. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.). 2. On May 4, 2010 at 2:49 pm surveyor #18107 observed in the 53-B1 smoke compartment on the 3rd floor that in the Stairwell #5-5 the stairwell was used for storage. Storage included a wood pallet. This observed situation was not compliant with NFPA 101 (2000 edition), 7.1.3.2.3. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 033	**K033** 1. Remove the wooden pallet at the bottom of Stairwell #3-1, located in 32-A1, and maintain a clear access to and from the exit. Responsible Person: [redacted] Director of Operations, [redacted], Operations & Maint. Supv 2. Remove the wooden pallet at the bottom of Stairwell #5-5, located on Unit 53-B1, and maintain a clear access to and from the exit. Responsible Person: [redacted], Director of Operations, [redacted], Operations & Maint. Supv	6/25/10 6/25/10
K 038	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 18107 Based on observation and interview, the facility did not provide egress paths at all times that had	K 038		

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K 038	Continued From page 26 doors that were unlockable in the egress path, no swinging door obstructions, doors that swing in the direction of egress, and level walking surfaces in the path of egress. This deficiency occurred in 9 of the 36 smoke compartments, and would affect 'ALL' of the 120 patients in the facility on the day of the survey, as well as staff and visitors.	K 038		
	FINDINGS INCLUDE: 1. On May 4, 2010 at 11:14 am surveyor #18107 observed in the 32-C1 smoke compartment on the 2nd floor that in the Stairwell #3-4 the door was locked from the egress side. The door has a manual deadbolt lock that was not positive self-latching. This observed situation was not compliant with NFPA 101 (2000 edition), 19.2.2.2.4. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		**K038** 1. Replace the hardware on the egress door in Stairwell #3-4, located on Unit 32-C1, with a positive self-latching lock. Responsible Person: [redacted] Director of Operations, [redacted], Operations & Maint. Supv	6/25/10
	2. On May 4, 2010 at 1:58 pm surveyor #18107 observed in the 32-A2 smoke compartment on the 2nd floor that in the Stairwell #32-A2 the door was locked from the egress side. A deadbolt was installed on the door that was not positive latching. This observed situation was not compliant with NFPA 101 (2000 edition), 19.2.2.2.4. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		2. Replace the hardware on the egress door in Stairwell #32-A2, located on Unit 32-A2, with a positive self-latching lock. Responsible Person: [redacted], Director of Operations, [redacted] Operations & Maint. Supv	6/25/10
	3. On May 4, 2010 at 8:35 am surveyor #18107 observed in the 32-D1 smoke compartment on the 2nd floor that in the #2003-Electrical Closet one or more doors swung outward into the exit path and obstructed the path because the fully-open doors extended more than 7" into the		3. 32-D 2003 electric closet will have the door guide removed so the door will fully open to < 7" from the wall. Responsible Person: [redacted] Director of Operations, [redacted]. Mech. Maintenance Superint.	6/25/10

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K 038	Continued From page 27 required egress width. This observed situation was not compliant with NFPA 101 (2000 edition), 7.2.1.4.4. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.), and Staff C (Crisis Dir.).	K 038		
	4. On May 4, 2010 at 9:35 am surveyor #18107 observed in the 32-D1 smoke compartment on the 2nd floor that in the 2124-Office one or more doors swung outward into the exit path and obstructed the path because the fully open door extended more than 7" into the required egress width. This observed situation was not compliant with NFPA 101 (2000 edition), 7.2.1.4.4. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.), and Staff C (Crisis Dir.).		4. 32-D 2124 will have the door guide removed so the door will fully open to < 7" from the wall. Responsible Person: [redacted], Director of Operations, [redacted]. Mech. Maintenance Superint.	6/25/10
	5. On May 7, 2010 at 11:55 am surveyor #18107 observed in the 31-B smoke compartment on the 1st floor that in the #1075-Electrical Room one or more doors swung outward into the exit path and obstructed the path because they extended more than 7" into the required egress width. This observed situation was not compliant with NFPA 101 (2000 edition), 7.2.1.4.4. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		5. 31-B 1075 electrical closet door will have the door guide removed so the door will fully open to < 7" from the wall. Responsible Person: [redacted], Director of Operations, [redacted]. Mech. Maintenance Superint.	
	6. On May 4, 2010 at 11:11 am surveyor #18107 observed in the 32-B1 smoke compartment on the 2nd floor that in the Stairwell #3-4 the door in the path of egress did not swing in the direction of egress travel and the occupancy load of the		6. Re-hang the gate that interrupts the travel past the exit discharge in Stairwell #3-4, located on Unit 32-B1 so that the gate swings in the direction of the egress travel.	6/25/10

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(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
K 038	Continued From page 28 egress was estimated to be at least 50 persons. The gate that interrupts the travel past the exit discharge swings against the direction of egress from the lower floor. This observed situation was not compliant with NFPA 101 (2000 edition), 7.2.1.4.2. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 038	Responsible Person: [redacted] Director of Operations, [redacted]. Mech. Maintenance Superint.	
	7. On May 3, 2010 at 2:21 pm surveyor #18107 observed in the 52-A2 smoke compartment on the 2nd floor that in the 52-A Stair Discharge a portion of the path of egress had an abrupt change in elevation of 4" to 5" between two (2) concrete slabs due to soil erosion. This observed situation was not compliant with NFPA 101 (2000 edition), 7.1.6 and 7.1.7. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		7. 52-A stair egress path sidewalk will be replaced to remove the elevation change. A purchase order has been issued, and the contractor indicates that this work is scheduled for completion by 10/1/2010. Responsible Person: [redacted], Director of Operations, [redacted], Mech. Utilities Engineer	10/10/10
	8. On May 5, 2010 at 3:00 pm surveyor #18107 observed in the 53-C smoke compartment on the 3rd floor that in the Staff Entrance a portion of the path of egress had an abrupt change in elevation of greater than 1/2" between the slab panels of the sidewalk. This observed situation was not compliant with NFPA 101 (2000 edition), 7.1.6 and 7.1.7. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		8. 53-C staff entrance sidewalk will be replaced to remove the elevation change. A purchase order has been issued, and the contractor indicates that this work is scheduled for completion by 10/1/10. Responsible Person: [redacted], Director of Operations, [redacted] Mech. Utilities Engineer	10/1/10
	9. On May 5, 2010 at 3:06 pm surveyor #18107 observed in the 53-C smoke compartment on the 3rd floor that in the Stair #5-1 a portion of the path of egress had an abrupt change in elevation		9. 53-C stair 5-1 egress path sidewalk will be replaced to remove the elevation change. A purchase order has been issued, and the contractor indicates that this work is scheduled for completion by 10/1/10.	10/1/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 038	Continued From page 29 of greater than 1/2" between the slab panels of the sidewalk. This observed situation was not compliant with NFPA 101 (2000 edition), 7.1.6 and 7.1.7. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 038	Responsible Person: [redacted], Director of Operations, [redacted], Mech. Utilities Engineer	
	10. On May 6, 2010 at 9:33 am surveyor #18107 observed in the 43-C2 smoke compartment on the 3rd floor that in the Stair #4-3-Exit Discharge a portion of the path of egress had an abrupt change in elevation of greater than 1/2" between the slab panels of the sidewalk. This observed situation was not compliant with NFPA 101 (2000 edition), 7.1.6 and 7.1.7. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		10. 43-C stair 4-3 egress path sidewalk will be replaced to remove the elevation change. A purchase order has been issued, and the contractor indicates that this work is scheduled for completion by 10/1/10. Responsible Person: [redacted], Director of Operations, [redacted], Mech. Utilities Engineer	10/1/10
	11. On May 6, 2010 at 11:54 am surveyor #18107 observed in the 42-A1 smoke compartment on the 2nd floor that in the Stair #4-2 Exit Discharge a portion of the path of egress had an abrupt change in elevation were 8 panels of sidewalk that were broken and this created an un-level egress path to a public way. This observed situation was not compliant with NFPA 101 (2000 edition), 7.1.6 and 7.1.7. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		11. 42-A stair 4-2 sidewalk broken panels will be repaired to remove the elevation change. A purchase order has been issued, and the contractor indicates that this work is scheduled for completion by 10/1/10. Responsible Person: [redacted] Director of Operations, [redacted], Mech. Utilities Engineer	10/1/10
	12. On May 6, 2010 at 2:35 pm surveyor #18107 observed in the 43-B1 smoke compartment on the 5th floor that in the Stair #4-5 Exit Discharge a portion of the path of egress had an abrupt		12. 43-B stair 4-5 egress path sidewalk will be replaced to remove the elevation change. A purchase order has been issued, and the contractor indicates that this work is scheduled for completion by 10/1/10.	10/1/10

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STREET ADDRESS, CITY, STATE, ZIP CODE: 9455 W WATERTOWN PLANK RD, MILWAUKEE, WI 53226

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K 038	Continued From page 30 change in elevation of greater than 1/2" between the slab panels of the sidewalk. This observed situation was not compliant with NFPA 101 (2000 edition), 7.1.6 and 7.1.7. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 038	Responsible Person: [redacted] Director of Operations, [redacted], Mech. Utilities Engineer	
	13. On May 6, 2010 at 4:09 pm surveyor #18107 observed in the 43-A1 smoke compartment on the 3rd floor that in the Stair #4-1 Exit Discharge a portion of the path of egress had an abrupt change in elevation of greater than 1/2" between the slab panels of the sidewalk. This observed situation was not compliant with NFPA 101 (2000 edition), 7.1.6 and 7.1.7. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		13. 43-A stair 4-1 exit path slab sections will be replaced to remove the elevation change. A purchase order has been issued, and the contractor indicates that this work is scheduled for completion by 10/1/10. Responsible Person: [redacted], Director of Operations, [redacted], Mech. Utilities Engineer	10/1/10
	14. On May 7, 2010 at 10:59 am surveyor #18107 observed in the 31-A smoke compartment on the 1st floor that in the Stair #3-1 a portion of the path of egress had an abrupt change in elevation of greater than 1/2" between the slab panels of the sidewalk. This observed situation was not compliant with NFPA 101 (2000 edition), 7.1.6 and 7.1.7. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		14. 31-A stair 3-1 exit path slab sections will be replaced to remove the elevation change. A purchase order has been issued, and the contractor indicates that this work is scheduled for completion by 10/1/10. Responsible Person: [redacted], Director of Operations, [redacted], Mech. Utilities Engineer Exit sidewalks will be annually inspected for trip and fall hazards with appropriate corrections made as necessary.	10/1/10
K 045	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency	K 045		

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K 045	Continued From page 31 lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Surveyor: 22219 Based on observation and interview, the facility did not provide and maintain multiple light fixtures or lamps in the interior and exterior means of egress so the path would still be illuminated if any single fixture or bulb failed and the egress paths would be walk-able with redundant lighting. This deficiency occurred in 7 of the 36 smoke compartments, and would affect 90 of the 120 patients in the facility on the day of the survey, as well as staff and visitors. FINDINGS INCLUDE: 1. On May 3, 2010 at 2:20 pm till 4 pm surveyor #18107 observed in the smoke compartment on the 1st, 2nd & 3rd floors that in the various Stairwells the path of egress was illuminated by a single light fixture with a single lamp, and did not have the ability to provide 0.2 foot-candles of lighting on the exit path if a single lamp was not operational. This condition was observed at various times in a number of Stairwells , including, but not limited to, the following examples: 43-H2: Stair #4-15 Exit Discharge; 43-C1: Stair #4-14 Exit Discharge; 43-C2: Stair #4-3 Exit Discharge; 43-D2: Exit Discharge; 52-A2: Stair #52A Exit Discharge; 52-B: Stair #52B D Exit Discharge; 53-A1: Stair #5-3 Exit Discharge; 53-C: Stair #5-1 Exit Discharge; This observed situation was not compliant with	K 045	**K045** 1. Exit discharges have been identified requiring 2 or more lamps / fixtures. Replacement 2 lamp light fixtures will be selected by 6/25/10. Replacement light fixtures are expected to be delivered by 8/13/10 or sooner. Installation is scheduled for completion by 9/13/10. In the interim the existing single lamp light fixtures will be checked 3 times per week that the lamp is working. Responsible Person: [redacted] Director of Operations, Mech. Utilities Engineer	6/25/10 8/13/10 9/13/10

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K 045	Continued From page 32 NFPA 101 (2000 edition), 7.8.1.4. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 045		
	2. On May 11, 2010 at 2:45 pm surveyor #18107 observed in the 53-A1 smoke compartment on the 3rd floor that in the Stair #5-2 the path of egress was illuminated by a single fixture with a single lamp, and did not have the ability to provide 0.2 foot-candles of lighting on the exit path if a single lamp was not operational. The light was burnt-out and the space was dark, come night. This observed situation was not compliant with NFPA 101 (2000 edition), 7.8.1.4. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		2.The 53-A stair 5-2 burnt out lamp will be replaced by 6/25/10. Note there are two other functioning lights in the stairway exit corridor. Responsible Person: [redacted], Director of Operations, [redacted], Mech. Utilities Engineer	6/25/10
K 051	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4,	K 051	**K051** see page 35	

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K 051	Continued From page 33 9.6 This STANDARD is not met as evidenced by: Surveyor: 22219 Based on observation and interview, the facility did not provide a fire alarm system that was installed according to NFPA 72. The Life Safety Code, section 9.6.1.4, requires approval of the authority having jurisdiction (AHJ) in an existing healthcare facility that is not installed in compliance with NFPA 72. The Wisconsin Department of Health Services and Centers for Medicare Services have not identified any exceptions to permit non-compliance with NFPA 72 in an existing healthcare facility. The AHJ considers any non-compliance a distinct hazard to life in existing facilities, since patients are incapable of self preservation and rely on a highly reliable fire alarm system to defend in place. This is consistent with NFPA 72 (1999 edition) 1-2.3, which notes that while NFPA 72 is not normally applied to existing facilities, the AHJ can apply it in cases where the AHJ feels there is a distinct hazard to life or property. The facility did not provide a fire alarm system that had visible alarm notification devices. This deficiency occurred in 1 of the 36 smoke compartments, and would affect 0 of the 120 patients in the facility on the day of the survey, as well as staff and visitors. FINDINGS INCLUDE:	K 051	**K051** see page 35	

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K 051	Continued From page 34 On May 11, 2010 at 9:25 am surveyor #18107 observed in the 42-A2 smoke compartment on the 2nd floor that in the #2208-Central Supply Room (Hardware Rm.) a visual fire alarm notification device was obstructed so it was not viewable from all areas of the space. The fire alarm visual device located on one of the walls was blocked for viewing by all areas of the room. This observed situation was not compliant with NFPA 72 (1999 edition), 4-4.3.1. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 051	Remove the shelving that obstructed the visual fire alarm notification device in Room #2208-Central Supply Room (Hardware Rm.) and maintain a free and clear space from the device. Responsible Person: [redacted], Director of Operations, [redacted] Mech. Maintenance Superint. 6/25/2010	6/25/10
K 056	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is 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 This STANDARD is not met as evidenced by: Surveyor: 18107 Based on observation and interview, the facility did not provide a sprinkler system that was installed according to NFPA 13 as required by the Life Safety Code, section 9.7.1.1. The Wisconsin	K 056	**K056** see page 36	

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K 056	Continued From page 35 Department of Health Services and Centers for Medicare Services have not identified any exceptions to permit non-compliance with NFPA 13 in an existing healthcare facility. The AHJ considers any non-compliance a distinct hazard to life in existing facilities, since patients are incapable of self preservation and rely on a highly reliable sprinkler system to defend in place. This is consistent with NFPA 13 (1999 edition) 1-3, which notes that while NFPA 13 is not normally applied to existing facilities, the AHJ can apply it in cases where the AHJ feels there is a distinct hazard to life or property. The facility did not provide a sprinkler system that had sprinklers free of obstructions near the ceiling, all rooms sprinkled when the code required sprinkling, and Stairwells with sprinklers. This deficiency occurred in 10 of the 36 smoke compartments, and would affect 'ALL' of the 120 patients in the facility on the day of the survey, as well as staff and visitors. FINDINGS INCLUDE: 1. On May 4, 2010 at 8:36 am surveyor #18107 observed in the 32-D1 smoke compartment on the 2nd floor that in the #2003-Storage Closet, items were placed near the ceiling within 18" below the sprinkler deflector that obstructed the discharge of sprinkler water from reaching the other side of the obstruction. The obstruction included items on shelves. This obstruction would interfere with the development of the water spray pattern and may reduce the amount of water that the code requires to reach all portions of the protected floor space. This observed situation was not compliant with NFPA 13 (1999 edition), 5-6.5. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.),	K 056	1. 32-D 2003 closet will have items removed from the top shelf. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Maintenance Superint.	6/25/10

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K 056	Continued From page 36 Staff DD (Oper.& Maint.Sprvsr.), and Staff C (Crisis Dir.).	K 056		
	2. On May 11, 2010 at 9:13 am surveyor #18107 observed in the 42-B2 smoke compartment on the 2nd floor that in the #2308-Central Supply/General Distribution Room, items were placed near the ceiling within 18" below the sprinkler deflector that obstructed the discharge of sprinkler water from reaching the other side of the obstruction. The obstruction included multiple storage shelves in the middle of the room with materials stored less than 12 inches below the sprinkler heads. This obstruction would interfere with the development of the water spray pattern and may reduce the amount of water that the code requires to reach all portions of the protected floor space. This observed situation was not compliant with NFPA 13 (1999 edition), 5-6.5. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		2. 42-B 2308 central supply shelf units will have materials removed to more than 18" below the sprinkler heads. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Maintenance Superint.	6/25/10
	3. On May 7, 2010 at 2:30 pm surveyor #18107 observed in the 31-B smoke compartment on the 1st floor that in the Data Room where Halon was the source of fire-suppression, the room was not sprinkler protected. The facility took advantage of a construction exception in the code, which required this space to be sprinkled. The room was equipped with a Halon extinguishing system, but was not considered effective because the mechanical ducts were not smoke-dampered to contain the gas within the room upon activation. This observed situation was not compliant with NFPA 101 (2000 edition). The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC		3. 31-B data room will be corrected per the POC submitted 5/11/10 with a completion date of 10/29/10. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Engineer	10/29/10

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(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
K 056	Continued From page 37 (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.). 4. On May 6, 2010 at 10:58 am surveyor #18107 observed in the various smoke compartment on the lowest floor that in the Stairwells the stairwell did not have a sprinkler at the first landing above the bottom of the shaft. The surveyor observed this deficiency in Stairwells #4-10, #4-3, #4-2, #3-2, #3-3, #3-4, and #4-3. This observed situation was not compliant with NFPA 13 (1999 edition), 5-13.3. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.). 5. On May 3, 2010 at 2:35 pm surveyor #18107 observed in the 52-B smoke compartment on the 2nd floor that in the #2318-Materials Management Store Room, the discharge of sprinkler water was prevented from reaching an unprotected area on the other side of the obstructing item. The obstruction included boxes and various materials stacked on the top of three (3) center aisle shelving units and the tops were less than 12" below the height of the sprinkler deflector. This observed situation was not compliant with NFPA 13 (1999 edition), 5-6.5. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.). 6. On May 3, 2010 at 2:40 pm surveyor #18107 observed in the 52-B smoke compartment on the 2nd floor that in the #2318-Materials Management Storeroom, the discharge of sprinkler water was prevented from reaching an unprotected area on the other side of the obstructing item. This	K 056	4. Add approved sprinkling system to the stairwell first landing above the bottom of the shaft in the following locations: Stairwell #4-10, Stairwell #4-3, Stairwell #4-2, Stairwell #3-2, Stairwell #3-3, Stairwell #3-4, Stairwell #4-3 Fire sprinklers will be installed at the bottom landing of stairwells that do not have a sprinkler head. A purchase order is scheduled to be issued by 6/25/10. Plans will be developed for state and local plan reviews. After plan approvals are received the work will be scheduled. It is expected that the work will be completed by 10/15/10. Responsible Person: [redacted] Director of Operations, [redacted], Mech. Utilities Engineer 5. Remove and re-stack items within Room #2318-Materials Management Store Room so that there are no obstructions within 18" of the sprinkler deflector. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Maintenance Superint. 6. Remove and re-stack items within Room #2318-Materials Management Store Room so that all areas of the room will receive discharged sprinkler water. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Maintenance Superint.	10/15/10 6/25/10 6/25/10

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	524001	A. BUILDING 03 - BLDG 1, 2, 3, 4, 5 MILW C B. WING	05/11/2010

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MILWAUKEE CTY BEHAVIORAL HLTH DIV	9455 W WATERTOWN PLANK RD MILWAUKEE, WI 53226

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K 056	Continued From page 38 observed situation was not compliant with NFPA 13 (1999 edition), 5-6.5. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 056		
	7. On May 4, 2010 at 8:38 am surveyor #18107 observed in the 32-D1 smoke compartment on the 2nd floor that in the #2005-Storage Closet, the discharge of sprinkler water was prevented from reaching an unprotected area on the other side of the obstructing item. The obstruction included items on shelves. This observed situation was not compliant with NFPA 13 (1999 edition), 5-6.5. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.), and Staff C (Crisis Dir.).		7. Remove and re-place shelving within Room #2005-Storage Closet so that the top shelf is less than 18" from the sprinkler deflector and no items are placed on the top shelf so that all areas within the closet receive sprinkled water in case of fire. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Maintenance Superint.	6/25/10
	8. On May 4, 2010 at 9:20 am surveyor #18107 observed in the 32-C1 smoke compartment on the 2nd floor that in the #1-Storage Closet, the discharge of sprinkler water was prevented from reaching an unprotected area on the other side of the obstructing item. The obstruction included materials stored on shelves. This observed situation was not compliant with NFPA 13 (1999 edition), 5-6.5. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.), and Staff C (Crisis Dir.).		8. Remove and re-place shelving within Room #1-Storage Closet, located on Unit 32-C1 so that the top shelf is less than 18" from the sprinkler deflector and no items are placed on the top shelf so that all areas within the closet receive sprinkled water in case of fire. Staff will be instructed of the fire code requirement to keep 18" or more clearance to sprinkler heads to prevent obstructing the spray from a sprinkler head. Regular environmental inspections will take note of violations of the 18" rule, with necessary actions to follow. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Maintenance Superint.	6/25/10
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested	K 062		

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MILWAUKEE CTY BEHAVIORAL HLTH DIV	9455 W WATERTOWN PLANK RD MILWAUKEE, WI 53226

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K 062	Continued From page 39 periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 22219 Based on observation, interview and a review of documents, the facility did not maintain the sprinkler system in a reliable operating condition that included a complete inspection program as required by NFPA 25. The sprinkler system did not have intact escutcheon rings, and ceilings sealed above the sprinklers to collect heat. This deficiency occurred in 10 of the 36 smoke compartments, and would affect 90 of the 120 patients in the facility on the day of the survey, as well as staff and visitors. FINDINGS INCLUDE: 1. On May 6, 2010 at 9:36 am surveyor #18107 observed in the smoke compartment on the 3rd and every other floor that in the occupied spaces the escutcheon ring on the sprinkler was missing, ajar, or damaged. This was observed throughout the facility at various times and in various smoke compartments, including, but not limited to the following examples: 43-B1: in #23-Electrical Closet, #37-Sleeping Room, #8 Toilet, #7-Sleeping Room, and #4-Tub Room; 43-C1: in #29-Seclusion Room, #3-Janitor Closet, #4-Shower Room, #10-Laundry Room, #35-Sleep Room, #40-Toilet Room, #13-Conference Room, and #24-Conference Room; 43-D: in Corridor, #2-Sleep Room, and #7-Sleep Room; 43-H1: in corridor #3208;#3-04-Women's Toilet; 21-N: in the French Quarter;	K 062	**K062** 1. Replace missing, ajar, or damaged escutcheon rings on the sprinklers located in the following areas: 43-B1: in #23-Electrical Closet, #37-Sleeping Room, #8-Toilet, #7-Sleeping Room, and #4-Tub Room; 43-C1: in #29-Seclusion Room, #3-Janitor Closet, #4-Shower Room, #10-Laundry Room, #35-Sleep Room, #40-Toilet Room, #13-Conference Room, and #24-Conference Room; 43-D: in Corridor, #2-Sleep Room, and #7-Sleep Room; 43-H1: in corridor #3208, #3-04-Women's Toilet; 21-N: in the French Quarter 31-A: in the Reception, Vestibule, #1039-2, #1039-3, #1039-4, and #1029-5 Offices; 31-B: in #1121-Suite, #1010-Gathering Room, Medical Records Room, Corridor by Janitor	6/25/10

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K 062	Continued From page 40 31-A: in the Reception, Vestibule, #1039-2, #1039-3, #1039-4, and #1039-5-Offices; 31-B: in #1121-Suite, #1010-Gathering Room, Medical Records Room, Corridor by Janitor Closet, and #1110-Suite Aisles; 32-D1: in the Corridor by Room 2116, Room #2120, #2109-Waiting; 32-C1: in #2132-8-Toilet Room, #3132-16-Consult Room, 32-B1: in the Corridor, #30-Room 32-A1: in #2102-31-Office 53-B1: in #6-Inpatient Room, #12-Dayroom, #40-Inpatient Room, Corridor by Room #40, #40A-Toilet Room; 53-C: in the Corridor by #3-Office. This gap would reduce the response time of the sprinkler in the room and did not duplicate the tight conditions that were used in the sprinkler escutcheon UL certification test. This observed situation was not compliant with NFPA 25 (1998 edition), 1-11.1. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 062	Closet, and #1110-Suite Aisles; 32-D1: in the Corridor by Room #2116, Room #2120, #2109-Waiting; 32-C1: in #2132-8-Toilet Room, #3132-16-Consult Room; 32-B1: in the Corridor, #30-Room; 32-A1: in #2102-31-Office; 53-B1: in #6-Inpatient Room, Corridor by Room #40, #40A-Toilet Room; 53-C: in the Corridor by #3-Office. Sprinkler escutcheon rings have been made available through the replacement of existing sprinkler heads. Sprinkler heads listed will have an escutcheon ring installed by 6/25/10. Regular environmental inspections will include noting any missing sprinkler escutcheon rings (sprinkler covers). Responsible Person: [redacted] Director of Operations, [redacted], Mech. Utilities Engineer	
	2. On May 6, 2010 at 9:04 am surveyor #18107 observed in the smoke compartment on the 1st, 2nd & 3rd floor that in the occupied areas there was one or more unsealed holes near the ceiling. The hole(s) included mis-aligned ceiling tile joints and gaps caused by damaged, out-of-place, or missing ceiling tiles or unsealed penetrations. This situation was observed throughout the facility, including but not limited to: 43-D1: in the Corridor by room #18, Nurse Station, #24-Office, and #13-Conference Room; 43-C1: in the corridor; 43-G1: in #3234-Music Therapy Room, and in the corridor by the Smoke Barrier;		2. Seal holes near the ceiling due to mis-aligned ceiling tile joints, gaps due to damage, out-of-place or missing ceiling tiles and unsealed penetrations in the following locations: 43-D1: in the Corridor by Room #18, Nurse Station, #24-Office, and #13-Conference Room; 43-C1: in the corridor; 43-G1 in #3234-Music Therapy Room, and in the corridor by the Smoke Barrier; 43-B1: in #23-Electrical Closet; 43-H1: in #3-Office 21-N: in#3-Office 53-B1: in #24-Electrical Closet, #13-	6/25/10

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K 062	Continued From page 41 43-B1: in #23-Electrical Closet; 43-H1: in #3-Office 21-N: in #3-Office 53-B1: in #24-Electrical Closet, #13-Conference Room 31-A1: in the entry vestibule to the Day Hospital; 31-B1: in #1120-suite; #2a-Court Room; 32-A1: #14-Office 32-D1: in #2013-Intake Foyer, Corridor by #2126-Office, #2126-Office 53-A1: in #24-Electrical Closet 53-C: in #3310-Staffing Suite Passage; These holes would reduce the response time of the sprinkler in the room and did not duplicate the tight conditions that were used in the sprinkler UL certification test. These observed situations were not compliant with NFPA 25 (1998 edition), 1-11.1. The deficiencies were confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.). 3. On May 11, 2010 at 2:47 pm surveyor #18107 observed in the 53-A1 smoke compartment on the 3rd floor that in the #3322-7-Inpatient Toilet Room there was one or more unsealed holes near the ceiling. The hole(s) included an opening in the valance light fixture because is was missing a lens. The fixture was located above the mirror at the handwashing lavatory. This hole would reduce the response time of the sprinkler in the room and did not duplicate the tight conditions that were used in the sprinkler UL certification test. This observed situation was not compliant with NFPA 25 (1998 edition), 1-11.1. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 062	Conference Room; 31-A1: in the entry vestibule to the Day Hospital; 32-D1: in#2013-Intake Foyer, Corridor by #2126-Office, #2126-Office; 53-A1: in #24-Electrical Closet 53-C: in #3310-Staffing Suite Passage The listed areas with ceiling tiles that are missing or damaged will be repaired by 6/25/10. Note that it may be necessary to open some of these ceiling areas to correct other K-tag deficiencies after 6/25/10. It is understood that this approach is less efficient for productivity than making the repairs after the work above the ceilings is completed. It is also understood that during any such work the ceiling needs to be closed at the end of the work day or other ILSM measures need to be implemented. Responsible Person: [redacted] Director of Operations, Mech. Utilities Engineer 3. 53-A room 7 toilet room fixture valance light filler plate will be installed to close the opening in the light fixture by 6/25/10. Responsible Person: [redacted] Director of Operations, Mech. Utilities Engineer	6/25/10

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K 072	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant 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: Surveyor: 22219 Based on observation and interview, the facility did not provide a means of egress that was free of impediments, including corridors free of materials that obstruct egress. This deficiency occurred in 1 of the 36 smoke compartments, and would affect 15 of the 120 patients in the facility on the day of the survey, as well as staff and visitors. FINDINGS INCLUDE: On May 3, 2010 at 3:17 pm surveyor #18107 observed in the 52-A2 smoke compartment on the 2nd floor that in the #52A Stair Discharge materials were stored in the exit access pathway, including a chair in the outside smoking area blocked the exit path. The materials were stored in this location for greater than 30 minutes and were not attended by a staff person that was responsible for their use. This observed situation was not compliant with NFPA 101 (2000 edition), 19.3.6.1 (exception 6), and 19.7.5.5. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 072	**K072** Remove all materials from Stairwell #52A Stair Discharge that were stored in the exit access pathway, including a chair in the outside smoking are that blocks the exit path. Keep and maintain all items away from all exits. Provide in-service training to all staff educating the purpose and importance of keeping clear exits. Responsible Person: [redacted]	6/25/10
K 075	NFPA 101 LIFE SAFETY CODE STANDARD	K 075		

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K 075	Continued From page 43 Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Surveyor: 22219 Based on observation and interview, the facility did not provide and maintain linen/trash collection receptacles in compliance with the code that had properly sized storage containers for soiled/trash materials. This deficiency occurred in 1 of the 36 smoke compartments, and would affect 0 of the 120 patients in the facility on the day of the survey, as well as staff and visitors. FINDINGS INCLUDE: On May 5, 2010 at 3:36 pm surveyor #18107 observed in the 43-H1 smoke compartment on the 3rd floor that in the #3204-Office Suite mobile collection receptacles exceeded the 32 gallon maximum size when located outside of a hazardous area. Two (2) large 32 gallon waste containers were next to each, along with other large volumes of paper supplies in the office. This quantity of combustible materials must be enclosed with walls and doors that are	K 075	**K075** Keep only (1) 32 gallon waste receptacle per room or keep 8' apart from one another unless the room is rated to store hazardous material. Responsible Person: [redacted]irector of Operations, [redacted]Mech. Maintenance Superint.	6/25/10

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K 075	Continued From page 44 appropriate for a hazardous space. This observed situation was not compliant with NFPA 101 (2000 edition), 19.7.5.5. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 075		
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 18107 Based on observation and interview, the facility did not provide and maintain an electrical installation compliant with NFPA 70, National Electrical Code that had working clearances at electrical panels, GFIC outlets, closed electrical raceways, and electrical panels with complete directories. This deficiency occurred in 13 of the 36 smoke compartments, and would affect 40 of the 120 patients in the facility on the day of the survey, as well as staff and visitors. FINDINGS INCLUDE: 1. On May 3, 2010 at 2:30 pm surveyor #18107 observed in the 52-B smoke compartment on the 2nd floor that in the #2317-Loading Dock access to electrical panel was less than 3'-0" clearance. A 32 gallon cart was parked in front of two electrical panels. This observed situation was not compliant with NFPA 70 (1999 edition), 110-26. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 147	**K147** 1. Remove the (1) 32 gallon cart to at least 3' of the two electrical panels located in Room #2317-Loading Dock and maintain this clearance at all time. Either place tape or paint lines on the floor that delineates the area that needs to be kept clear. Responsible Person: [redacted] Director of Operations, Mech. Maintenance Superint.	6/25/10

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K 147	Continued From page 45	K 147		
	2. On May 4, 2010 at 9:14 am surveyor #18107 observed in the 32-D1 smoke compartment on the 2nd floor that in the #7-Electrical Panel Room access to electrical panel was less than 3'-0" clearance. This observed situation was not compliant with NFPA 70 (1999 edition), 110-26. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.), and Staff C (Crisis Dir.).		2. Remove all items within Room#7-Electrical Panel Room located on 32-D1, to maintain a clearance not less than 3' from the electrical panel. In addition, keep all non-electrical items from being stored in this electrical closet. Either place tape or paint lines on the floor that delineates the area that needs to be kept clear. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Maintenance Superint.	6/25/10
	3. On May 4, 2010 at 10:40 am surveyor #18107 observed in the 32-C1 smoke compartment on the 2nd floor that in the #19-Storage Closet access to electrical panel was less than 3'-0" clearance. This observed situation was not compliant with NFPA 70 (1999 edition), 110-26. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		3. Remove all items within Room#19-Storage Closet located on 32-C1, to maintain a clearance not less than 3' from the electrical panel. Either place tape or paint lines on the floor that delineates the area that needs to be kept clear. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Maintenance Superint.	6/25/10
	4. On May 6, 2010 at 9:42 am surveyor #18107 observed in the 43-C1 smoke compartment on the 3rd floor that in the #19-Clean Supply Store Room access to electrical panel was less than 3'-0" clearance. Access to the electrical panel was blocked by a clean supply cart. This observed situation was not compliant with NFPA 70 (1999 edition), 110-26. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		4. Move clean supply cart in Room#19-Clean Supply Store Room, located on 43-C1, to maintain a clearance not less than 3' from the electrical panel. Either place tape or paint lines on the floor that delineates the area that needs to be kept clear. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Maintenance Superint.	6/25/10
	5. On May 6, 2010 at 9:59 am surveyor #18107 observed in the 43-D1 smoke compartment on		5. Move clean supply cart in Room#19-Clean Supply Store Room, located on 43-D1, to maintain a clearance not less than 3' from the	6/25/10

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(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
K 147	Continued From page 46 the 3rd floor that in the #19-Clean Supply Store Room access to electrical panel was less than 3'-0" clearance. Access to the electrical panel was blocked by a clean supply cart. This observed situation was not compliant with NFPA 70 (1999 edition), 110-26. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 147	electrical panel. Either place tape or paint lines on the floor that delineates the area that needs to be kept clear. Responsible Person: [redacted] Director of Operations, Mech. Maintenance Superint.	
	6. On May 6, 2010 at 3:06 pm surveyor #18107 observed in the 43-B1 smoke compartment on the 3rd floor that in the #9-Closet access to electrical panel was less than 3'-0" clearance. Access to the electrical panel was blocked by a clean supply cart. This observed situation was not compliant with NFPA 70 (1999 edition), 110-26. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		6. Move clean supply cart in Room#19-Clean Supply Store Room, located on 43-B1, to maintain a clearance not less than 3' from the electrical panel. Either place tape or paint lines on the floor that delineates the area that needs to be kept clear. Responsible Person: [redacted] Director of Operations, Mech. Maintenance Superint.	6/25/10
	7. On May 11, 2010 at 9:21 am surveyor #18107 observed in the 42-A2 smoke compartment on the 2nd floor that in the #2208-Central Supply Room (Hardware Rm.) access to electrical panel was less than 3'-0" clearance. The electrical panel was blocked by several boxes and a cart parked in front of the electrical panel. This observed situation was not compliant with NFPA 70 (1999 edition), 110-26. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		7. Move several boxes and a cart parked in front of the electrical panel in Room#2208-Central Supply Room (Hardware Rm.) located in 52-A2, to maintain a clearance not less than 3' from the electrical panel. Either place tape or paint lines on the floor that delineates the area that need to be kept clear. Responsible Person [redacted] Director of Operations, Mech. Maintenance Superint.	6/25/10
	8. On May 11, 2010 at 2:25 pm surveyor #18107 observed in the 53-A1 smoke compartment on		8. Move the storage shelves that are placed in front of the electrical panel located in Room #20-Storage Closet, located on Unit 53-A1, to	6/25/10

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	524001	A. BUILDING 03 - BLDG 1, 2, 3, 4, 5 MILW C B. WING	05/11/2010

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K 147	Continued From page 47 the 3rd floor that in the #20-Storage Closet access to electrical panel was less than 3'-0" clearance. Storage shelves where placed in front of the electrical panel. This observed situation was not compliant with NFPA 70 (1999 edition), 110-26. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 147	maintain a clearance not less than 3' from the electrical panel. Either place tape or paint lines on the floor that delineates the area that need to be kept clear. Responsible Person: [redacted] Director of Operations, Mech. Maintenance Superint.	
	9. On May 4, 2010 at 1:53 pm surveyor #18107 observed in the 32-A1 smoke compartment on the 2nd floor that in the #28-Pantry an outlet within 4' of a sink was not equipped with a ground fault circuit interruption device. A toaster was plugged into the outlet. This observed situation was not compliant with NFPA 70 (1999 edition), 210-8. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		9. Replace the existing electrical outlet located within 4' of a sink in Room #28-Pantry, located on Unit 32-A1, with a Ground Fault Interrupt outlet Responsible Person: [redacted] Director of Operations, Operations & Maint. Supv	7/1/10
	10. On May 6, 2010 at 11:10 am surveyor #18107 observed in the 43-F1 smoke compartment on the 3rd floor that in the Corridor by Smoke Barrier a 4" x 4" electrical box did not have a cover so the raceway system was not enclosed. This observed situation was not compliant with NFPA 70 (1999 edition), 517-12. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		10. Replace the missing 4"x4" cover on the electrical box on the 3rd floor Corridor by Smoke Barrier, located on Unit 43-F1. Responsible Person: [redacted] Director of Operations, Operations & Maint. Supv	7/1/10
	11. On May 6, 2010 at 11:20 am surveyor #18107 observed in the 42-H1 smoke compartment on the 2nd floor that in the Electrical Switchgear Room a 4" x 4" electrical box did not have a cover so the raceway system was not enclosed. This		11. Replace the missing 4"x4" cover on the electrical box on the 2nd floor in the Electrical Switchgear Room, located on 42-H1. Responsible Person: [redacted] Director of Operations, Operations & Maint. Supv	7/1/10

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K 147	Continued From page 48 observed situation was not compliant with NFPA 70 (1999 edition), 517-12. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 147		
	12. On May 7, 2010 at 11:01 am surveyor #18107 observed in the 31-A smoke compartment on the 1st floor that in the #1039-Infection Control Office a two (2) gang electrical box did not have a cover so the raceway system was not enclosed. This observed situation was not compliant with NFPA 70 (1999 edition), 517-12. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		12. Replace the missing cover on the two (2) gang electrical box within Room#1039-Infection Control Office. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv	7/1/10
	13. On May 7, 2010 at 2:42 pm surveyor #18107 observed in the 31-B smoke compartment on the 1st floor that in the #1038-6-Court Room a 4"x4" electrical box did not have a cover so the raceway system was not enclosed. This observed situation was not compliant with NFPA 70 (1999 edition), 517-12. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		13. Replace the missing 4"x4" cover on the electrical box in Room #1038-6-Court Room. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv	7/1/10
	14. On May 11, 2010 at 9:23 am surveyor #18107 observed in the 42-A2 smoke compartment on the 2nd floor that in the #2208-Central Supply Room (Hardware Rm.) a duplex electrical box did not have a cover so the raceway system was not enclosed. This observed situation was not compliant with NFPA 70 (1999 edition), 517-12. The deficiency was confirmed at the time of discovery by a concurrent observation and		14. Replace the missing cover on the duplex electrical system in Room #2208-Central Supply Room (Hardware Rm.). Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv	7/1/10

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K 147	Continued From page 49 interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 147		
	15. On May 11, 2010 at 2:22 pm surveyor #18107 observed in the 53-A1 smoke compartment on the 3rd floor that in the #31- Pantry and #17-Inpatient Art Supplies Room a double gang electrical box did not have a cover so the raceway system was not enclosed. This observed situation was not compliant with NFPA 70 (1999 edition), 517-12. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		15. Replace the missing covers on the double gang electrical box in Rooms #31-Pantry and #17-Inpatient Art Supplies Room, located on Unit 53-A1. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv	7/1/10
	16. On May 4, 2010 at 9:15 am surveyor #18107 observed in the 32-D1 smoke compartment on the 2nd floor that in the #7-Electrical Panel Room electrical panel breaker(s) were not labeled to identify the loads they fed. This observed situation was not compliant with NFPA 70 (1999 edition), Section 110-22. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.), and Staff C (Crisis Dir.).		16. Label the electrical panel breakers in Room #7-Electrical Panel Room, located on Unit 32-D1 Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv	7/1/10
	17. On May 4, 2010 at 2:09 pm surveyor #18107 observed in the 32-A1 smoke compartment on the 2nd floor that in the #19-Clean Supply Store Room and #23-Electrical Closet electrical panel breaker(s) were not labeled to identify the loads they fed. This observed situation was not compliant with NFPA 70 (1999 edition), Section 110-22. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).		17. Label the electrical panel breakers in Room #19-Clean Supply Store Room and #23-Electrical Closet, located on Unit 32-A1. Responsible Person: [redacted], Director of Operations, [redacted] Operations & Maint. Supv.	7/1/10

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K 147	Continued From page 50 18. On May 4, 2010 at 3:18 pm surveyor #18107 observed in the 53-B1 smoke compartment on the 3rd floor that in the #24-Electrical Closet electrical panel breaker(s) were not labeled to identify the loads they fed. This observed situation was not compliant with NFPA 70 (1999 edition), Section 110-22. The deficiency was confirmed at the time of discovery by a concurrent observation and interview with Staff CC (Mech.Util.Engr.), Staff DD (Oper.& Maint.Sprvsr.).	K 147	18. Label the electrical panel breakers in Room #24-Electrical Closet, located on Unit 53-B1. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv.	7/1/10
			The Governing Body will ensure that the facility has and uses sufficient resources to appropriately manage the facility and maintain a clean, safe environment. On 6/7/10 the Division Administrator directed the appointment of a standing Environment of Care Committee to be chaired by the Division's Assistant Administrator - Environment of Care Compliance. The Environment of Care committee members will include engineering, maintenance, operations. infection control, dietary and house keeping representatives. The committee will begin meeting by 6/25/10. The committee will meet at regular intervals and the chair shall directly report to the governing body. Responsible Persons: [redacted] BHD Administrator [redacted] Director of Operations [redacted] Operations Coordinator [redacted] Assistant Administrator – Environment of Care Compliance	6/25/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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A 000	INITIAL COMMENTS Surveyor: 26711 An unannounced on-site recertification survey was conducted from 5/3/10-5/11/10 at Milwaukee County Behavioral Health Division in Milwaukee WI. Milwaukee County Behavioral Health Division was found to be out of compliance with Federal Conditions of Participation for Hospitals at 42 CFR 482 in the areas of Patient Rights, Medical Records, Pharmacy, Infection Control, Maintenance, Physical Plant, and Governing Body. 42 CFR 482.12 Condition of Participation: Governing Body: NOT MET 42 CFR 482.12 (e) Standard: Contracted Services: NOT MET 42 CFR 482.41 Condition of Participation: Physical Environment: NOT MET 42 CFR 482.41(a) Standard: Maintenance of Physical Plant: NOT MET 42 CFR 482.41(b) Standard: Life Safety from Fire: NOT MET 42 CFR 482.42 Condition of Participation: Infection Control: NOT MET 42 CFR 482.42(a) Standard: Organization and Policies: NOT MET Also completed during this survey was a complaint investigation for complaint #WI00014469. There are no citations related to the complaint.	A 000	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was correctly cited. This Plan of Correction is submitted to comply with State and Federal laws.	
A 043	482.12 GOVERNING BODY The hospital must have an effective governing	A 043	**A043** The governing body will be effective in its responsibility for managing the facility. The hospital's governing body will oversee contracted services that are responsible for food safety and sanitation and medical record storage (See A 085 and A 441). The hospital's infection control practitioner will ensure a clean and sanitary environment (See A 749). The hospital's infection control practitioner will develop and implement a hospital-wide infection control surveillance system (See A748)	6/25/10

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

BHD Administrator 6/14/10

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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A 043	Continued From page 1 body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION is not met as evidenced by: Surveyor: 26711 Based on observations, policy and procedure review, and staff interview, the hospital's governing body failed to be effective in its responsibility for managing the hospital which affects all patients, staff and visitors. Findings include: The hospital failed to manage and oversee contracted services which are responsible for food safety and sanitation, and medical record storage. See A085, and A441 for for details. The hospital infection control practitioner failed to ensure a clean and sanitary environment. See A749 for details. The hospital infection control practitioner failed to develop and implement a hospital-wide infection control surveillance system; including off-campus locations. See A748 for details. The hospital maintenance department failed to maintain a safe and properly maintained environment. See A700 and A701 for details. The cummulative effect of these systematic problems resulted in the failure of the hospital's governing body to effectively direct and manage services.	A 043	The hospital's maintenance department will maintain a safe and properly maintained environment (See A 700 and A 701). The Governing Body will ensure that the facility has and uses sufficient resources to appropriately manage the facility and maintain a clean, safe environment. On 6/7/10 the Division Administrator directed the appointment of a standing Environment of Care Committee to be chaired by the Division's Assistant Administrator - Environment of Care Compliance. The Environment of Care committee members will include the infection control practitioner and representatives from dietary, engineering, maintenance and cleaning operations. The committee will begin meeting by 6/25/10. The committee will meet at regular intervals and the chair shall directly report to the governing body. The Medical Records Director and Contract Services Coordinator will oversee the contractor responsible for maintaining off-site patient records by: • Reviewing the contract and business agreements with the provider to ensure all aspects of the agreements are being followed. Completed 6-17-10. • Conducting a site visit to the provider's facility. Completed 6-17-10. • Reviewing, and updating as necessary, the providers contract record. They will report their findings and detail the plan for compliance monitoring to the governing body on 6/21/10. Responsible Persons: [redacted], BHD Administrator [redacted], Acute Inpatient Admin. [redacted], Crisis Services Administrator	6/25/10 6/25/10

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A 085	482.12(e)(2) CONTRACTED SERVICES The hospital must maintain a list of all contracted services, including the scope and nature of the services provided. This STANDARD is not met as evidenced by: Surveyor: 26711 Based on review of policy and staff interview, observations and tours, the hospital failed to oversee and manage two of two contracted services to ensure these contracted services were appropriate and functioned effectively. These failed practices affects all hospital patients, staff and visitors. Findings include: On 5/4/10 between 8:00 AM and 10:15 AM Surveyor #22198 toured the on-site areas defined as "dishwashing" area, "food set-up" area, and "dry storage" area, and the off-site kitchen (food production) and storage area with BHD Administrator J, Aviands Lead O (contracted service), and Food Services Assistant Director Q. Interview with Administrator J confirmed that Aviands is a contracted service and is responsible for the cleaning and sanitation of these areas. In interview with Aviands Lead O and Administrator J, confirmed that the hospital's Infection Control Practitioner S does not provide oversight or guidance in the dietary departments, and acknowledged the need for infection control oversight. (See A748 and A749 for details). In interview with Medical Records Director B on 5/3/10 at 1:10 p.m revealed that the hospital contracts with an off-site storage location to	A 085	**A085** Management and Oversight of Contract Svs The Infection Control Practitioner will provide oversight & guidance to Dietary Dept (seeA748) Contract administration will work with the ICP to provide oversight and guidance to the dietary Department by: • Meet with the dietary management staff to review and update cleaning schedules for completeness and timeframes. Completed 6-8-10. • Ensure that the dietary department has a plan to monitor the work done per the cleaning schedule. Completed 6-8-10. • Develop a plan to audit the dietary department's cleaning schedule and monitoring system. Completed 6-25-10. Facility will manage and oversee contracted services responsible for maintaining confidentiality of patient records (see A 749). Contract services will oversee the contractor responsible for maintaining off-site patient records by: • Reviewing the contract and business agreements with the provider to ensure all aspects of the agreements are being followed. Completed 6-17-10. • Conducting a site visit to the provider's facility. Completed 6-17-10. • Reviewing, and updating as necessary, the providers contract record. As part of the overall BHD contract management plan, Milwaukee County will oversee and manage contracted services to ensure dietary and off-site medical record storage are appropriate and effective through the following: • Maintain a record for each contractor, which includes, but is not limited to,	6/25/10 6/25/10

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A 085	Continued From page 3 maintain patient medical records when the hospital can no longer keep them on site. Medical Records Director B confirmed that employees of this contracted service have access to documents within a patient's medical record. There is no documentation that this contract is reviewed to assure patient confidentiality. (See A441 for details). This finding was discussed and confirmed on 5/4/10 at 4:00 p.m. with Quality Director A, Administrators D, F, and J, and Directors C and G.	A 085	infection control plans, copies of contracts and agreements, contract deliverable plans and audit data. Records will be maintained within the contract administration area of the Fiscal Dept. • Complete an annual site visit of any off-campus facilities to insure contract compliance. • Review all contracts and agreements for compliance with contract deliverables and compliance with federal, state, county and facility policies. Policies include, but are not limited to HIPAA, Infection Control, and reporting standards. • Work within the Contract Monitoring committee(s) to continue to develop contract deliverables, contractor scorecards and reports as a means to ensure contract deliverables are provided. • Work within the Infection Control Program (ICP) to continue to develop a surveillance system including contract deliverables, standards and reports as a means to ensure ICP practices are in place for all contracted services. • Contract Services Coordinator will be an active member of the IC Committee and begin attending on 06/08/2010. • Contract Services coordinator will oversee IC inspection results from all the contract service departments. • A meeting was held on 06/08/10 with ICP, Dietary and Contract Service coordinator to discuss inspection rounds. A schedule of at least biannual IC inspection(s) of Dietary Department will be established by 06/25/10. Responsible parties: [redacted], Contract Services Coordinator, [redacted], Medical Records Director, [redacted], Infection Control Preventionist	
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Surveyor: 26711 Based on observation and staff interview, this hospital does not ensure that patient's physical safety is maintained by failing to remove potential obstacles and hazardous materials that could be used for self-injury on 4 of the 5 inpatient units (Units A, B, C and D). Findings include: A tour of acute inpatient unit A was conducted on 5/3/10 at 3:00 p.m. accompanied by Administrator D, Registered Nurse (RN) I, and Manager EE. It was noted that in the laundry room on unit A that fixtures for the wash machine were exposed on the outside of the wall which could allow patients to harm themselves. Administrator D confirmed there could be an occasion when a patient could be in this room unsupervised for a short amount	A 144		

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A 144	Continued From page 4 of time. This finding was confirmed by Administrator D, RN I, and Manager EE at the time of discovery during the tour. A tour of acute inpatient unit B was conducted on 5/3/10 at 3:40 p.m. accompanied by Administrator D, Registered Nurse (RN) I, and Manager EE. Room #40, confirmed by Manager EE to be unoccupied, was found to be unlocked. Unlocked and unoccupied rooms could provide an environment for a patient to harm themselves or others. Manager EE confirmed this room should have been locked. This finding was confirmed by Administrator D, RN I, and Manager EE at the time of discovery during the tour. A tour of acute inpatient unit C was conducted on 5/5/10 at 9:15 a.m. accompanied by Administrator D, Registered Nurse (RN) I, and Manager EE. It was discovered in room #35 that one of the beds had bed rails attached. Bed rails could pose a risk to patient safety. Administrator D confirmed that the bed rails should not be on the bed. This finding was confirmed by Administrator D, RN I, and Manager EE at the time of discovery during the tour. A tour of acute inpatient unit D was conducted on 5/5/10 at 10:30 a.m. accompanied by Administrator D, Registered Nurse (RN) I, and Manager EE. In the laundry room it was discovered that the fixtures for the wash machine were loose and not secured to the wall. The pipes could pose a risk to patient safety.	A 144	**A144** Facility will ensure that patients receive care in a safe setting, free of potential obstacles and hazardous materials that could be used for self-injury. Create a locked cabinet for the washing machine fixtures located in the laundry room on Acute Inpatient Unit A so only Hospital staff has access to the fixtures. Because this work will require an outside contractor and the requirement of bids, this work will be completed by 10/1/2010. Responsible Person: [redacted], Director of Operations, [redacted], Mech. Utilities Engineer Unit nursing staff will conduct rounds, per policy, to ensure rooms are secured. Responsible Person: [redacted], Associate Administrator of Nursing Remove the bed rails from the bed located in Room #35, located in Acute Inpatient Unit C. Responsible Person: [redacted], Director of Operations, [redacted], Operations & Maint. Supv Create a locked cabinet for the washing machine fixtures after securing them to the wall in the laundry room on Acute Inpatient Unit D so that only Hospital staff has access to the fixtures. Because this work will require outside contractors and the requirement of bids, this work will be completed by 10/1/2010.	10/1/10 6/25/10 6/25/10 10/1/10

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A 144	Continued From page 5 This finding was confirmed by Administrator D, RN I, and Manager EE at the time of discovery during the tour. Surveyor #18107: Based on tours with Staff CC (Mech.Util.Engr.), and Staff DD (Oper.& Maint.Sprvsr.) it was observed that: 1. On May 6, 2010 at 10:49 am surveyor #18107 observed in the 43-D1 smoke compartment on the 3rd floor that in the #4-Tub Room, the guard at the heater was missing and exposed the sharp surfaces of the heating fins. 2. On May 6, 2010 at 4:09 pm surveyor #18107 observed in the 43-A1 smoke compartment on the 3rd floor that in the Stair 4-1 the guard at the heater was missing and exposed the sharp surfaces of the heating fins. 3. On May 7, 2010 at 10:42 am surveyor #18107 observed in the 31-A smoke compartment on the 1st floor that in the Corridor to the Day Hospital, the cover at the heater had several gaps and exposed the sharp surfaces of the heating fins. 4. On May 11, 2010 at 2:20 pm surveyor #18107 observed in the 53-A1 smoke compartment on the 3rd floor that in the #3322-31-Child & Adolescent Pantry, that the patient-designated refrigerator/freezer unit was missing trim above the doors, which exposed the mechanical/electrical components of the equipment. These observations were confirmed by Staff CC and Staff DD.	A 144	Responsible Person: [redacted], Director of Operations, [redacted], Operations & Maint. Supv 1. Replace the missing guard on the heater within Room #4-Tub Room, located on the Unit 43-D1. Responsible Person: [redacted], Director of Operations, [redacted], Operations & Maint. Supv 2. Replace the missing guard on the heater within the stairwell 4-1, located on Unit 43-A1. Responsible Person: [redacted], Director of Operations, [redacted], Operations & Maint. Supv 3. Replace the cover on the heater within the corridor of the Day Hospital, located on 31-A. Responsible Person: [redacted], Director of Operations, [redacted], Operations & Maint. Supv 4. Replace the refrigerator within Room #3322-31-Child and Adolescent Pantry, located on Unit 53-A1. Responsible Person: [redacted], Director of Operations, [redacted], Operations & Maint. Supv To ensure ongoing compliance, the program administrators will conduct environmental rounds quarterly. Rounds will include focus on potential obstacles and hazardous materials that could be used for self-injury. Responsible persons: [redacted], Acute Inpatient Administrator [redacted], Crisis Services Administrator [redacted] Director of Operations [redacted] Assistant Administrator-Environment of Care Compliance	6/25/10 6/25/10 6/25/10 6/25/10 6/25/10
A 441	482.24(b)(3) CONFIDENTIALITY OF MEDICAL RECORDS	A 441		

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A 441	Continued From page 6 The hospital must have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals. This STANDARD is not met as evidenced by: Surveyor: 26711 Based on observation and staff interview, this hospital does not ensure that unauthorized individuals at one of one off site storage locations do not have access to information in patient records. Findings include: An interview with Medical Records Director B was conducted on 5/3/10 at 1:10 p.m. It was determined during the interview that an off site storage location, under contract with the hospital, stores hospital patient medical records when they can no longer be kept on site. A number on the box is used as an identifier for tracking and location purposes, however according to Medical Records Director B, "The company will pull a record from the box and send it over and they have been asked to fax individual documents from records if they are needed in a hurry." Unauthorized individuals handling patient medical records and extracting forms to fax to the hospital does not maintain the confidentiality of the medical record. These findings were discussed and confirmed on 5/4/10 at 4:00 p.m. in the presence of 15 attendees, some of who included Quality Director A, Administrators D, F, and J, Directors C and G.	A 441	**A441** Contract services will oversee the contractor responsible for maintaining off-site patient records by: • Reviewing the contract and business agreements with the provider to ensure all aspects of the agreements are being followed. Completed 6-17-10. • Conducting a site visit to the provider's facility. Completed 6-17-10. • Reviewing, and updating as necessary, the providers contract record. To ensure corrections are achieved and sustained, the Director of Medical Records and Contract Services Coordinator will ensure the confidentiality of patient records by: • Complete an annual site visit of any off-campus facilities to insure contract compliance. • Review the contract and agreements for compliance with contract deliverables and compliance with federal, state, county and facility policies. Policies include, but are not limited to record access, HIPAA, and reporting standards. • Work within the Contract Monitoring committee(s) to continue to develop contract deliverables, contractor scorecards and reports as a means to ensure contract deliverables are provided. Responsible Parties: [redacted], Contract Services Coordinator [redacted], Director of Medical Records and [redacted], Director of Operations	6/25/10
A 450	482.24(c)(1) MEDICAL RECORD SERVICES	A 450		

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A 450	Continued From page 7 All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Surveyor: 26711 Based on medical record review and staff interview this hospital did not ensure that required information was included on all medical records forms; such as proper authentication of orders and forms (5 out of 30 medical records reviewed[redacted]), documentation of parent/guardian notification (1 out of 15 medical records out of a total of 30-[redacted]), and inclusion of involuntary medications (2 out of 20 medical records out of a total of 30-[redacted]). In 3 out of 30 medical records ([redacted], [redacted]) discharge order forms were prematurely signed. Surveyor: 22198 Findings include: On 05/06/10 between 7:30 am - 9:00 am Surveyor #22198 conducted interviews and record reviews and identified the following: [redacted] had Discharge Physicians orders that were signed, however the Patients were not being discharged on 05/06/10, and the orders had not been completed. This was confirmed in an interview with M, Acting Interim Manager for the Child and Adolescent Inpatient Service (CAIS). [redacted] Admission Summary and order sheet	A 450	**A450** The facility will ensure that: ▪ All telephone orders will be properly authenticated within 48 hours of their origination. ▪ All required Guardian consents and notifications will be documented in the medical record. ▪ All orders will be properly signed, timed, and dated by the responsible Registered Nurse and transcription staff. ▪ Emergency involuntary medication orders will appear on the appropriate form and be listed as chemical restraint. ▪ All forms must be completed prior to Medical Staff signature. ▪ Behavioral Observation Sheets will be reviewed and signed by the responsible Registered Nurse.	6/25/10

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A 450	Continued From page 8 was not signed/timed or dated by a Registered Nurse, and the transcription staff failed to date and time their signature. This was confirmed in an interview with M, Acting Interim Manager for the CAIS unit. [redacted]	A 450	On 6/14/2010, the Medical Director sent a memo to the Medical Staff reminding them of responsibilities pertinent to: • Authentication of Telephone Orders within 48 hours of their origination. • Assuring documentation of all required Guardian consents and notifications. • Assuring completion of all forms prior to their signature. • Assuring that orders for emergent use of involuntary medication appear on the appropriate form as chemical restraint. An audit of patients' medical records will be conducted to ensure compliance with these standards. Responsible Person: [redacted] Medical Director	
			The RN and Unit Clerk staff in the Acute Inpatient Program will be given written instruction regarding the expectation to date, time and sign the form entitled: *PCS/Admission Center Risk Summary and Suicide and Behavior Observation Medical Staff Order Form.* Compliance of this expectation will be monitored. Ten audits per unit each week will be completed until June 23, 2010. Responsible Party: [redacted], Associate Administrator of Nursing	6/25/10
A 466	482.24(c)(2)(v) CONTENT OF RECORD - INFORMED CONSENT [All records must document the following, as appropriate:] Properly executed informed consent forms for procedures and treatments specified by the	A 466	The RN staff in the CAIS program will be given written instruction regarding expectations for documentation of seclusion and/or restraint episodes. The instruction will include a review of the required elements to date and time all entries, parent/guardian notification at the time of restraint or seclusion and the documentation of emergent involuntary medication use. The Seclusion and Restraint documentation	6/25/10

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A 466	Continued From page 9 medical staff, or by Federal or State law if applicable, to require written patient consent. This STANDARD is not met as evidenced by: Surveyor: 26711 Based on medical record review and staff interview, the hospital failed to obtain proper informed consent from a legal guardian in 1 out 3 [redacted] adult patients with guardians. Findings include: An interview was conducted on 5/4/2010 at 1:30 p.m. with Lead Social Worker (SW) BB and Administrator G. SW BB stated that if a patient had a guardian because the patient was found to be incompetent, "We would not have an incompetent person sign their own consent forms." [redacted] An "Informed Consent to Receive Psychotropic Medications" form, dated 5/4/10, is signed by [redacted]	A 466	forms from the CAIS program will be monitored daily during the week of June 13. Feedback will be given to the appropriate staff by nursing management at the time of the review. Responsible Party: [redacted], Associate Administrator of Nursing and [redacted], Nursing Program Coordinator The facility RN staff will review the Behavior Observation Flow Sheet for their assigned patients for accuracy, completion and authenticate the document with a date, signature and time at the end of the shift. Auditing will be conducted to ensure compliance with this expectation. Ten audits per unit each week will be completed until June 23, 2010. Progressive discipline will be done for those staff not in compliance. Responsible Party: [redacted], Associate Administrator of Nursing **A466** The facility will ensure that: ▪ Forms requiring Guardian signature will be properly completed whenever possible. ▪ When a Guardian is unable to be physically present to sign a required consent form, the Guardian's verbal consent will be documented in the medical record. ▪ When a Guardian is unavailable, all reasonable attempts to contact him/her will be made and these efforts will be documented in the medical record. On 6/14/2010, the Medical Director sent a memo to the Medical Staff reminding them of these requirements. An audit of patients' medical records will be conducted to assure compliance with this standard. Responsible Person: [redacted], Medical Director	6/25/10 6/25/10

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A 466	Continued From page 10 [redacted] These findings were confirmed by Nurse Manager FF on 5/6/10 at 3:30 p.m.	A 466	On 5/26/2010, the Social Work Director held a meeting with the Social Work staff reviewing the need for Guardian involvement in discharge planning, and documentation thereof in the medical record. On 6/9/2010, the Social Work Director held a meeting with the Social Work staff and reviewed the following: ▪ Forms requiring Guardian signature will be properly completed whenever possible. ▪ When a Guardian is unable to be physically present to sign a consent form, a verbal consent will be documented in the medical record. ▪ When a Guardian is unavailable, all reasonable attempts to contact him/her will be made and these efforts will be documented in the medical record An audit of patients' medical records will be conducted to ensure compliance with these standards. Responsible Person: [redacted] Social Work Director	6/25/10
A 469	482.24(c)(2)(viii) CONTENT OF RECORD - DISCHARGE DIAGNOSIS [All records must document the following, as appropriate:] Final diagnosis with completion of medical records within 30 days following discharge This STANDARD is not met as evidenced by: Surveyor: 20878 Based on 2 of 9 medical records reviewed [redacted], staff interview and medical staff rules and regulations, the hospital failed to ensure medical records were complete within 30 days of discharge. Findings include: According to the facility's Medical staff Rules and Regulations section 2.10.2; "In order to meet the 30 day requirement, discharge summaries should be dictated within 20 days of discharge, which allows 10 days for final completion." [redacted]	A 469	The RN staff will be instructed in the expectation to contact a patient's guardian to complete/authorize the completion of the "*Consent to Acknowledge Presence Form*" upon admission to the hospital. The compliance of the completion of this form will be audited for those patients that have guardians. Responsible party: [redacted], Associate Administrator of Nursing **A469** Facility will ensure medical records are complete within 30 days. [redacted] In 6/10/10 the Medical Director sent a memo to the medical staff reminding them	6/25/10 6/25/10

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A 469	Continued From page 11 [redacted] These findings were confirmed in interview with Medical Records Director B at 1:30 PM on 05/06/2010.	A 469	that all discharge summaries and signatures must be completed within 30 days of discharge. Audits of incomplete/delinquent records are now reported monthly. This will be increased to weekly for the month of June. Beginning July 1, 2010, audits will be reported on a twice-monthly basis to better monitor compliance. This data is reported into the Medical Staff Executive Committee annually. Persons responsible: [redacted]	
A 505	482.25(b)(3) UNUSABLE DRUGS NOT USED Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use. This STANDARD is not met as evidenced by: Surveyor: 26711 Based on observation, staff interview, and policy and procedure review this hospital failed to follow its policy for dating multi-use vials of insulin in 1 of 5 medication rooms observed and did not properly label 1 vial of insulin for a specific patient in 1 out of 5 medication rooms observed. Findings include: The hospital's Pharmacy Policy and Procedure Manual was reviewed on 5/4/10 at approximately 2:00 p.m. Page 12, section 11.00 "Monthly Nursing Station Inspections" D. states, "Multi-dose vials are initialed and dated when first used..." Hospital policy #46:00 titled "Infection Control Multidose Vial Expiration Dates," which was revised on 9/06 states in section A. 1. "Multi-dose vials for injection should be dated (month/day/year)and initialed by the nurse who first uses them." A tour of hospital inpatient units A and B was conducted on 5/3/10 between 3:00 p.m. and 4:15	A 505	**A505** The facility will ensure that medications are stored under proper conditions and that outdated, mislabeled or unusable medications are not available for patient use. The facility will ensure that multi-dose vials are dated when first used • All BHD nurses have been inserviced regarding maintaining the integrity of refrigerated medications. This training specifically addressed dating and initialing vials when first opened, that outdated or mislabeled medication must not be available for patient use and that insulin and PPD will not be used after 28 days from first opening. • Bright stickers have been ordered to affix to the vials to assist in legible labeling of the vials. • Laminated signs have been placed on the refrigerators reminding nurses to date and initial multi-dose vials and that insulin and PPD cannot be used after 28 days from first opening. To ensure ongoing compliance, beginning 6/1/10, the Acute Inpatient medication refrigerators are audited weekly to verify that any multi-dose vials present are not outdated and are dated/initialed when first entered. For	6/25/10

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A 505	Continued From page 12 p.m. accompanied by Administrator D, Registered Nurse (RN) I, and Manager EE. In the medication room refrigerator on unit A an opened vial of Lantus insulin was found without the date on which it was opened or the initials of who opened it. In the same refrigerator, two vials of Novolin insulin were found opened and without dates of when they were opened or initials of who opened them. One of these vials of insulin belonged to a patient who had been discharged. In the medication room refrigerator on unit B, an opened vial of insulin was found that did not identify which patient it belonged to. RN I confirmed that the insulin should have been in a bag labeled with the patient's name. These findings were confirmed by Administrator D, Manager EE, and RN I during the tours on 5/3/10.	A 505	any instance of non-compliance immediate corrective action is taken and the manager is notified. The audits will be reviewed at each Acute Executive Committee meeting until 100% compliance is attained for one month. When 100% compliance is reached for one month, the auditing will be reduced to monthly. Responsible Persons: [redacted], Associate Administrator of Nursing [redacted], Quality Improvement Director [redacted], Roeschen's Pharmacy	
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Surveyor: 22219 Based on observation, staff interviews, review of maintenance documents, and policy and procedure review, the facility did not maintain the building systems to ensure a safe physical environment. These deficiencies occurred in all of the 36 smoke compartments, and would affect	A 700	**A700** The hospital will be constructed, arranged and maintained to ensure the safety of all patients, staff and visitors. The facility will provide a safe, clean and properly maintained environment in compliance with NFPA 101-Life Safety Codes (See A 701, A 726 and the K tags). All staff will complete a mandatory inservice by 6/25/10 to acknowledge their role in ensuring a safe, clean and well-maintained hospital. The Governing Body will ensure that the facility has and uses sufficient resources to appropriately manage the facility and maintain a clean, safe environment. On 6/7/10 the Division Administrator directed the appointment of a standing Environment of Care Committee to be chaired by the Division's	6/25/10

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A 700	Continued From page 13 all patients in the facility on the day of the survey, as well as staff and visitors. The cumulative effect of these deficiencies resulted in the hospital's inability to ensure a safe and clean environment for all patients. Findings include: On May 11, 2010 surveyor #18107 observed that the facility had the following deficiencies: K12 (building type), K17 (corridor walls), K18 (corridor doors), K25 (smoke barrier walls), K27 (smoke barrier doors), K29 (hazardous rooms), K33 (stairwells), K38 (egress), K45 (redundant lighting), K51 (fire alarm), K56 (sprinklers), K62 (sprinkler inspections), K72 (egress obstructions), K75 (hazardous carts), and K147 (electrical). Refer to the full description of the deficient practice at the cited K-tags. On tours of the hospital from May 3, 2010 through May 11, 2010, observations reflect the hospital failed to maintain a safe and sanitary environment for all patients. See A701 and A726 for details.	A 700	Assistant Administrator - Environment of Care Compliance. The Environment of Care committee members will include engineering, maintenance, operations. infection control, dietary and house keeping representatives. The committee will begin meeting by 6/25/10. The committee will meet at regular intervals and the chair shall directly report to the governing body. Responsible Persons: [redacted] BHD Administrator [redacted] Director of Operations [redacted] Operations Coordinator [redacted] Assistant Administrator – Environment of Care Compliance	
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Surveyor: 22219 Based on observation, staff interviews, and review of standards of practice for infection control, the facility did not maintain the condition of the physical plant and overall hospital environment in a manner to ensure a safe	A 701	**A701** Facility will maintain the condition of the physical plant and overall hospital environment in a manner to ensure safety.	

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A 701	Continued From page 14 environment. Environmental tours reflected ceilings, walls and floors in disrepair, broken fixtures, insufficient lighting, poor ventilation, and rooms locked without keys. This deficiency occurred in all of the 36 smoke compartments, all inpatient units, and would affect all patients in the facility on the day of the survey, as well as staff and visitors. Findings include: By Surveyor #18107: Tour by Surveyor #18107 began on May 3, 2010 at 2:15 PM through May 7, 2010 at 1:55 PM and on May 11, 2010 from 8:20 AM to 2:59 PM. with Staff CC (Mech.Util.Engr.), and Staff DD (Oper.& Maint.Sprvsr.). All observations were confirmed by Staff CC and Staff DD.	A 701		
	1. On May 6, 2010 at 10:05 am surveyor #18107 observed in the 43-D1 smoke compartment on the 3rd floor that in the #26 & #29-Seclusion Rooms a portion of the ceiling was damaged and in need of repair. A patient observation mirror was forceably removed from the ceiling and created a damaged surface that was not repaired. The room was left without a means of observing the patient in all areas.		1. Ceilings in #26 and #29 of 43-D1 will be repaired using a contractor The patient observation mirror will be replaced to ensure all areas of the room can be observed. Due to the need to order all of the tiles and the labor to install them, this work will be completed by 8/1/2010. Responsible person: [redacted], Director of Operations, [redacted], Operations & Maint. Supv	8/1/10
	2. On May 6, 2010 at 11:35 am surveyor #18107 observed in the smoke compartment on the 2nd and every other floor in the occupied spaces, the following areas had damaged ceilings in need of repair: 21-N: in the staff toilet, #1011-PT Contract Company, French Quarter Area (16 stained tiles) 31-A: in #1030-7-Meehan Office, #1030-General Office #1039-2-Office, #1031-Suite, Gift Shop, #1042-Consumer Affairs Office, #1007-Mail Room, #1030-Office, #1063B-CEO, #1046-Office, #1060-Medical Director, 1046-Office,		2. Ceilings to be repaired or tiles to be replaced in the following locations: 21-N: in the staff toilet, #1011-PT Contract Company, French Quarter Area (16 stained tiles); 31-A: in #1030-7-Meehan Office, #1030 General Office, #1039-2-Office, #1031-Suite, Gift Shop, #1042-Consumer Affairs Office, #1007-Mail Room, #1030-Office, #1063B-CEO, #1046-Office, #1060 Medical Director, 1046-Office, #1069 Office, and #1071-Suite; 31-B: in #1093 Office, #1095-Office,	8/1/10

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILWAUKEE CTY BEHAVIORAL HLTH DIV	9455 W WATERTOWN PLANK RD MILWAUKEE, WI 53226

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A 701	Continued From page 15 #1069-Office, and #1071-Suite; 31-B: in #1093-Office, #1095-Office, #1096-4-Office, #1118-6-Office, 1120-5-Office, #1120-1-Office, #1038-3, #1038-4, #1038-10; #1038-11-Offices, Main Court Room and Closet, and #1084-Storage Room; 32-A1: in #19-Office, #14-Office, #3-Housekeeping; 32-B1: in #2111-Consult Room; 32-C1: in #5-Janitor Closet, Corridor, #24-Conference Room; 32-D1: in Corridor, Crisis Center, #4-Storage Room, Room #2114; 42-A2: #2208-Central Supply (Hardware Room); 42-B1: in the Maintenance Locker Room; 42-B2: in #2308-Central Supply/General Distribution Room; 42-A1: in the Dyna Care Lab; 43-D1: in the corridor, by smoke barrier doors 43-H1; in the corridor, by smoke barrier doors; 43-B1: in #3-Housekeeping Closet, #4-tube Room, #13-Conference Room, #20-Dictation Room, Corridor behind the Nurse Station, #21-Staff Toilet, #25-TV Room, Corridor outside of Resident Rooms #29-30 and #37-38, corridor by the smoke barrier, and the Nurse Station; 43-A1: #16-Office, #14-Office, #20-Charting, #38-Sleeping Room, #30-Sleeping Room, Corridor by the smoke barrier doors, and corridor by room 2; 43-H1: in #4-Office; 53-A1: in the Corridor, #27-Classroom; #21-Staff Chart Room; 53-B1: in Corridor, Stairwell #5-5, #27-OT Room, #14-Classroom; 53-C: in #3309-Housekeeping Closet, #3304-Office Suite Work Area, #5-Office, #6-Office, #7-Office, Corridor by #7-Office, #3315-Passage in Staffing Suite, #3312-Staffing	A 701	#1096-4 Office, #1118-6-Office, 1120-5-Office, #1120-1-Office, #1038-3, #1038-4, #1038-10; #1038-11-Offices, Main Court Room and Closet, and #1084 –Storage Room; 32-A1: in #19-Office, #14-Office, #3-Housekeeping; 32-B1: in #2111-Consult Room; 32-C1: in #5-Janiotr Closet, Corridor, #24-Conference Room, 32-D1: in: Corridor, Crisis Center, #4-Storage Room, Room #2114; 42-A2: #2208-Central Supply (Hardware Room); 42-B1: in the Maintenance Locker Room; 42-B2: in #2308-Central Supply/General Distribution Room; 42-A1: in the Dyna Care Lab; 43-D1: in the corridor, by smoke barrier doors 43-H1: in the corridor, by smoke barrier doors 43-B1: in #3-Housekeeping Closet, #4-tub Room, #13-Conference Room, #20-Dictation Room, Corridor behind the Nurse Station, #21-Staff Toilet, #25-TV Room, Corridor outside of Resident Rooms, #29-30 and #37-38 corridor by the smoke barrier, and the Nurse Station; 43-A1: #16-Office, #14-Office, #20-Charting, #38-Sleeping Room, #30-Sleeping Room, Corridor by the smoke barrier doors, and corridor by Room 2; 43-H1: in #4-Office 53-A1: in the Corridor, #27-Classroom; #21-Staff Chart Room; 53-B1: in Corridor, Stairwell #5-5, #27-OT Room, #14-Classroom; 53-C: in #3309-Housekeeping Closet, #3304-Office Suite Work Area, #5-Office, #6-Office, #7-Office, Corridor by #7-Office, #3315 Passage in Staffing Suite, #3312-Staffing Office, Stairwell #5-1, and the Women's Toilet. Due to the need to order all of the tiles and the labor to install them, this work will be	

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A 701	Continued From page 16 Office, Stairwell #5-1, and the Women's Toilet. 3. On May 6, 2010 at 4:39 pm surveyor #18107 observed in the 21-N smoke compartment on the 1st floor that in the #1025-7-Office a portion of the ceiling was damaged and in need of repair. 4. On May 11, 2010 at 8:57 am surveyor #18107 observed in the 52-A2 smoke compartment on the 2nd floor that in the #2336-Acute Clothing Room a portion of the ceiling was damaged and in need of repair. The paint on the exposed concrete beams was peeling away at several locations within the room. 5. On May 3, 2010 at 2:15 pm surveyor #18107 observed in the 52-A1 smoke compartment on the 2nd floor that in the #2314-Office debris from construction was not removed. Debris from opening a concrete block wall above the ceiling was not removed. The debris covered a 2'x4' area. 6. On May 6, 2010 at 9:46 am surveyor #18107 observed in the smoke compartment on the 3rd and every other floor that in the occupied spaces, caulk was missing: 31-B: in the Men's Toilet Room; 32-D1: in Nurse Station Med Area; 42-B1: in the Maintenance Toilet Room; 42-B2: in #2308-Central Supply/General Distribution Room; 43-A1: in #17-Clean Utility, #28-Pantry, and #9-Soiled Utility; 43-B1: in #39-Utility Room, #10-Laundry Room, #15-Exam Room, #17-Clean Utility, #22-Satelite Med Room, and #28-Pantry; 43-C1: in the #22-Medication Room, #17-Clean Utility Room, and #9-Soiled Utility Room; 43-D1: in the #17-Clean Utility Room, #22-Medication Room, and #9-Utility Room; #28-Pantry; 43-H2: in #3208-Staff Lounge, #3210 OT Class	A 701	completed by 8/1/2010. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv 3. Ceilings to be repaired or tiles to be replaced in 21-N smoke compartment on the 1st floor in office #1025-7. Due to the need to order all of the tiles and the labor to install them, this work will be completed by 8/1/2010. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv 4. Ceiling to be repaired on 52-A2 in Room #2336-Acute Clothing Room as well as repaint the exposed concrete beams within the same room. Due to the need to order all of the tiles and the labor to install them, this work will be completed by 8/1/2010. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv 5. Remove the debris covering a 2'x4' area located on 52-A1 in #2314-Office created by opening a concrete block wall above ceiling. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv 6. Re-caulk the following locations: 31-B: in the Men's Toilet Room; 32-D1: in Nurse Station Med Area; 42-B1: in Maintenance Toilet Room; 42-B2: in #2308-Central Supply/General Distribution Room; 43-A1: in #17-Clean Utility, #28-Pantry, and #9-Soiled Utility; 43-B1: in #39-Utility Room, #10-Laundry Rm, #15-Exam Room, #17-Clean Utility, #22-	8/1/10 8/1/10 6/25/10 6/25/10

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A 701	Continued From page 17 Room, #3211-OT Activity Room, and #3217-On Call Room; 53-C: in #3311-Staffing Office. 7. On May 7, 2010 at 11:49 am surveyor #18107 observed in the 31-A smoke compartment on the 1st floor that in the #1055-Staff Toilet a portion of a caulk joint was missing. The plumbing fixtures were not caulked at the wall. This situation was also observed in the 31-B unit in #1088 and the Women's Toilet Room and Toilet. 8. On May 6, 2010 at 10:39 am surveyor #18107 observed in the 43-D1 smoke compartment on the 3rd floor that in the #10-Laundry Room a portion of the counter was damaged and in need of repair. The counter surfacing material was delaminated. 9. On May 6, 2010 at 10:39 am surveyor #18107 observed in the 43-D1 smoke compartment on the 3rd floor that in the #10-Laundry Room there was a build-up of lint and dust in the laundry equipment. Behind the laundry dryer was a collection of dust covering an area of 36"x 3" x 1". Behind the laundry washer a collection of dirt covered an area of 36"x 3"; all of which poses a fire hazard. 10. On May 4, 2010 at 2:37 pm surveyor #18107 observed in the 53-B1 smoke compartment on the 3rd floor that in the #1-Inpatient Room a portion of the flooring was damaged and in need of repair. The metal threshold into the shower stall was painted with a glossy material and was slippery. There was also damaged flooring near the door. 11. On May 7, 2010 at 10:50 am surveyor #18107 observed in the smoke compartment on the 1st and every other floor that in the occupied spaces, flooring was damaged and in need of repair: 31-A: in #1030-Office and #1045-Conference Room and #1040-Men's Toilet Room;	A 701	Satellite Med Room, and #28-Pantry; 43-C1: in the #22-Medication Room, #17-Clean Utility Room, #9-Soiled Utility Room; 43-D1: in the #17-Clean Utility Rm;#22-Medication Room, #9-Utility Rm, #28-Pantry; 43-H2: in #3208-Staff Lounge, #3210-OT Class Room, #3211-OT Activity Room, and #3217-On Call Room; 53-C: in #3311-Staffing Office Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv	
			7. Replace the caulk joint missing within #1055-Staff Toilet located on 31-A. In addition, caulk the plumbing fixtures at the wall in this same site. Replace the caulk joint missing in Unit 31-B room #1088 and the Women's Toilet Room and Toilet. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv	6/25/10
			8. Replace the damaged counter in #10-Laundry Room located on 43-D1 with a laminate top that can be thoroughly cleaned. Because a new countertop needs to be ordered and the labor to install it, the work will be completed by 7/25/2010. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv	7/25/10
			9. Eliminate the fire hazard caused by the build-up of dust, dirt and lint located in #10-Laundry Room on 43-D1 behind the laundry dryer as well as establish a regular schedule for cleaning behind all dryers located throughout the hospital Responsible Person: [redacted] Director of Operations, [redacted] Mech. Maintenance Superint.	6/25/10

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A 701	Continued From page 18 31-B: in the Men's Toilet Room; 21-N: in the Transcription area; 42-B: in the Maintenance Locker Room and Toilet Room; 43-C1: in the #1- Inpatient Sleep Room; 43--D2: in Sleep Room #37; 43-H1:in #3-04A-Women's Locker Room and the Men's Toilet; 43-B1: in #4-Tub Room, #8-Toilet Room, #24-Seclusion Room, and #37-Toilet Room; Courtyard; 43-A1: in #36-Toilet Room; 53-A1: in #10-Laundry, and #31-Pantry; 52-A2: in #2336-Acute Clothing Room; 53-A1: in #27-Class Room; #31-Pantry, #10-Laundry; 53-C: in #3306A-Staff Locker Room 12. On May 5, 2010 at 11:35 am surveyor #18107 observed in the 22-N smoke compartment on the 2nd floor, that the Atrium Exterior Wall had a portion of a wall damaged and in need of repair. The exterior brick veneer was pulling away from the window sill at the upper story of the atrium space. The damage is about 10 lineal feet and the crack is between 3 to 4 inches wide. Some of the brick veneer is dangling on the window sill edge. 13. On May 6, 2010 at 11:35 am surveyor #18107 observed in the smoke compartment on the 1st, 2nd & 3rd floor, in the occupied spaces, walls were damaged and in need of repair: 31-A: in #1044-Housekeeping Room; Kitchen behind the hood; 43-A1: in #38-Toilet, #37-Toilet, #36-Sleeping Room, #2-Toilet; 43-B1: in #3223 Men's Public Toilet, #2-Patient Room, #30-Toilet; 42-B: Maintenance Locker Room - The wall behind the sink was damaged and wet;	A 701	10. Repair the two areas of damaged floor, and replace the metal threshold in to the shower stall in Inpatient Room #1 on 53-B1. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv 11. Repair or replace the damaged floors that are located in the following areas: 31-A: in #1030-Office and #1045-Conference Room and #1040-Men's Toilet Rm; 31-B: in the Men's Toilet Room; 21-N: in Transcription Area; 42-B: in the Maintenance Locker Room and Toilet Room; 43-C1: in the #1-Inpatient Sleep Room; 43-D2: in Sleep Room #37; 43-H1: in #3-04A-Women's Locker Room and the Men's Toilet; 43-B1: in #4-Tub Room, #8-Toilet Room, #24-Seclusion Room, and #37-Toilet Room, Courtyard; 43-A1: in #36-Toilet Room; 53-A1: in #10-Laundry, and #31-Pantry; 52-A2: in#2336-Acute Clothing Room; 53-A1: in #27-Class Room, #31-Pantry, #10-Laundry; 53-C: in#3306A-Staff Locker Rm. Because the ceramic wall tile being ordered must match existing tile, masonry work will be completed by 9/1/10. Because carpet replacement in the transcription and locker rooms will require bids to be received and delivery of carpet approximately eight weeks from initial request, plus the labor to install it, the work will be completed by 11/1/2010. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Engineer 12. Repair the 10 lineal feet of damaged windowsill of the Atrium Exterior Wall on 22-N where the brick veneer is pulling away and has resulted in a crack that is 3 to 4 inches wide leaving bricks dangling on the edge of the windowsill. Because this work will require outside contractors and the requirement of	6/25/10 9/1/10 11/1/10 10/1/10

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A 701	Continued From page 19 43-C2: in #37-Toilet Room, #4-Tub Room; 43-C1: in #28-Kitchenette and #26-Seclusion Toilet Room; 43-D1: #10-Laundry Room - A section of wall baseboard was damaged; 43-D1: #31-Patient Room - A section of wall baseboard was damaged; 43-D2: in #35 Sleep Room; 53-A1: in #37-Teacher's Room, #34-Storage 14. On May 7, 2010 at 11:16 am surveyor #18107 observed in the smoke compartment on the 1st and every other floor in the occupied areas, walls were damaged and in need of repair. Damaged walls showed evidence of the growth of black mold. (See A749 for reference to Standards of Practice regarding infection control and mold): 31-B:in the Janitor Closet; 42-B: in #3-Janitor Closet; 43-D1: in #3-Janitor Closet; 43-H1:in #3206-Housekeeping Room; 43-H1:in Housekeeping Room #3206; 53-A1: in #3-Janitor Closet; 53-B1: in #3-Janitor Closet; 53-CC: in #3309-Housekeeping Closet 15. On May 11, 2010 at 8:55 am surveyor #18107 observed in the 52-A2 smoke compartment on the 2nd floor that in the #2336-Acute Clothing Room, a portion of the wall was damaged and in need of repair. The east and south walls had vertical stains in numerous locations due to seepage of water from leaks in the foundation wall. Towels were dispersed around the perimeter of room to soak-up the water along the exterior walls. This room is used for storage. 16. On May 11, 2010 at 11:36 am surveyor #18107 observed in the 52-B1 smoke compartment on the 2nd floor that in the #2307A & #2311- Patient Storage Rooms a portion of the walls were damaged and in need of repair. The	A 701	bids, this work will be completed by 10/1/10. Responsible Person: [redacted] Director of Operations, [redacted], Mech. Utilities Engineer 13. Repair damaged walls that are located in the following locations: 31-A: in #1044-Housekeeping Room, Kitchen behind the hood; 43-A1: in #38-Toilet, #37-Toilet, #36 Sleeping Room, #2-Toilet; 43-B1: in #3223-Men's Public Toilet, #2 Patient Room, #30-Toilet; 42-B: Maintenance Locker Room – The wall behind the sink was damaged and wet; 43-C2: in #37-Toilet Room, #4-Tub Room; 43-C1: in #28-kitchenette and #26-Seculsion Toilet Room; 43-D1: #10-Laundry Room – A section of wall baseboard was damaged; 43-D2: in 31-Patient Room – A section of wall baseboard was damaged; 43-D2: in #35 Sleep Room; 53-A1: in #37-Teacher's Room, #34-Storage Because the ceramic wall tile being ordered must match existing file, masonry work will be completed by 9/1/10. The lower sections of the janitor closet walls are to be clad with vinyl covering, which needs to be ordered, coupled with contractors installing the material, the work will be completed by 10/1/10. The patient bathroom vinyl covering will be completed by 9/1/10. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Engineer 14.Remove all black mold or repair damaged walls due to black mold found in the following locations: 31-B: in the Janitor Closet; 42-B: in #3-Janitor Closet; 43-D1: in #3-Janitor Closet; 43-H1: in #3206-Housekeeping Room; 53-A1: in #3-Janitor Closet; 53-B1: in #3-Janitor Closet; 53-CC: in #3309-Housekeeping Closet Vinyl	9/1/10 10/1/10 10/1/10

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A 701	Continued From page 20 exterior foundation and inside wall surface had water damage from leakage through the wall foundation caused by leaks from the interior courtyard located on the level above. 17. On May 11, 2010 at 2:58 pm surveyor #18107 observed in the 53-A1 smoke compartment on the 3rd floor in the #3322-2-Facilities Management Storage Room, and in the #3322-1-Facilities Management Storage Rooms, the rooms were locked and no one had keys to open the rooms. 18. On May 3, 2010 at 3:35 pm surveyor #18107 observed in the 52-A1 smoke compartment on the 2nd floor in the #2326-Main Electrical Vault, 18" of insulation was missing on a hot water pipe and 12" on another. 19. On May 4, 2010 at 8:33 am surveyor #18107 observed in the 32-D1 smoke compartment on the 3rd floor in the Crisis Center Toilet room, the metal cover plate on the heater was rusted. 20. On May 4, 2010 at 10:12 am surveyor #18107 observed in the smoke compartment on the 2nd and 3rd floors, in occupied spaces, that the smell of sewer gas was coming from floor/shower drains: 32-C1: in #5-Tub Room; 32-A2: in #30 Office Toilet; #26-Office Toilet; 53-A1: in #36-Patient Toilet Room; 53-C: in the Men's Public 21. On May 4, 2010 at 2:46 pm surveyor #18107 observed in the 53-B1 smoke compartment on the 3rd floor that in Stairwell #5-5, the gate that interrupts the travel past the exit discharge would not close. 22. On May 6, 2010 at 10:35 am surveyor #18107 observed in the 43-D1 smoke compartment on the 3rd floor that the #11-Clean Linen Room had two water pipes that were not insulated for about 12" of length.	A 701	covering that will cover the lower sections of the walls needs to be ordered, coupled with contractors installing the material, will result in the project being completed by 10/1/2010. Responsible Person: [redacted] Director of Operations, Mech. Maintenance Superint. 15. Repair the damaged foundation walls in 52-A2, #2336-Acute Clothing Room, where vertical stains located on the east and south walls show seepage of water from leaks in the foundation wall as well as remove stains from interior walls. A contract must be awarded to repair the foundation, requiring bids, and then labor to repair the leaks. The project will be completed by 10/1/2010. Responsible Person: [redacted] Director of Operations, Mech. Utilities Engineer 16. Repair the foundation wall of the courtyard above rooms #2307A and #2311-Patient Storage Rooms, located on 52-B1. Once that repair is made, then repair the walls of those two rooms that occurred when water seeped along the inside wall surfaces. A contract must be awarded to repair the foundation, requiring bids, and then labor to repair the leaks. The project will be completed by 10/1/2010. Responsible Person: [redacted] Director of Operations, Mech. Utilities Engineer 17. Change the locks on the doors of Rooms #3322-2 and 3322-1-Facilities Management Storage Rooms on Unit 53-A1 so that the Mechanical Maintenance Engineer, the Mechanical Maintenance Supervisor and the Operating and Maintenance Supervisor have access to these two rooms.	10/1/10 10/1/10 6/25/10

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A 701	Continued From page 21 23. On May 6, 2010 at 10:48 am surveyor #18107 observed in the 43-D1 smoke compartment on the 3rd floor that in the #8-Public Toilet room the tissue dispenser was damaged and not repaired. 24. On May 7, 2010 at 10:46 am surveyor #18107 observed in the 31-A smoke compartment on the 1st floor that in the Corridor to the Day Hospital, the door to the fire hose cabinet would not close and latch. 25. On May 11, 2010 at 9:01 am surveyor #18107 observed in the 52-A2 smoke compartment on the 2nd floor that in the #2336-Acute Clothing Room, the door handle to the washer/dryer room was obstructed by a cabinet/shelving unit which obstructs access to the room 26. On May 3, 2010 at 2:40 pm surveyor #18107 observed in the 52-A1 smoke compartment on the 2nd floor that in the Janitors Closet lighting was not working. 27. On May 7, 2010 at 10:29 am surveyor #18107 observed in the 31-A smoke compartment on the 1st floor that the Food Storage space was not properly lighted. 28. On May 4, 2010 at 2:00 pm surveyor #18107 observed in the 53-A1 smoke compartment on the 3rd floor that in the #28-Office visable accumulation of dirt and dust were present. Dust was hanging from the ceiling. 29. On May 7, 2010 at 10:19 am surveyor #18107 observed in the 31-A smoke compartment on the 1st floor that in the Electrical Closet the room had visible dust on the floor and door frame. 30. On May 6, 2010 at 10:48 am surveyor #18107 observed in the 43-D1 smoke compartment on the 3rd floor that in the #8-Public Toilet the exhaust grills had a accumulation of	A 701	Responsible Person: [redacted], Director of Operations, [redacted] Mech. Maintenance Superint. 18. Place 18" of insulation that was missing from a hot water pipe and 12" of insulation missing from another hot water pipe in Room #2326-Main Electrical Vault, located on Unit 52-A1. Responsible Person: [redacted], Director of Operations, [redacted] Mech. Maintenance Superint. 19. Replace the rusted metal plate on the heater in the Crisis Center Toilet room located on Unit 32-D1. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv 20. Regularly flush the floor and shower drains with water to prevent sewer gas to emanate from the following locations: 32-C1: in#5-Tub Room; 32-A2: in #30-Office Toilet, #26-Office Toilet; 53-A1: in #36-Patient Toilet Room; 53-C: in the Men's Public Toilet. In addition, maintain a log of all vacant rooms with a schedule of regularly flushing floor and shower drains. Responsible Person: [redacted] Director of Operations, [redacted]. Mech. Maintenance Superint. 21.Repair or replace the gate within stairwell #5-5 located on Unit 53-B1 so that when closed, all travel is interrupted before the exit discharge. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Maintenance Superint. **CONTINUED ON ATTACHMENT #2 - A701**	6/25/10 6/25/10 6/25/10 6/25/10

ATTACHMENT #2 – A701
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POC 41GC11 CMS – 5/11/10
Milwaukee County Behavioral Health Division

22. Insulate two water pipes that had approx. 12" of exposed pipe within Room #11-Clean Linen Room located on Unit 43-D1. — 6/25/10
Responsible Person:
[redacted] Director of Operations,
[redacted] Operations & Maint. Supv.

23. Replace the damaged tissue dispenser within Room #8-Public Toilet Room, located on Unit 43-D1. This specialty toilet paper dispenser, currently on back order, will be installed by 8/1/2010. — 8/1/10
Responsible Person:
[redacted] Director of Operations
[redacted] Operations & Maint. Supv

24. Repair the door to the fire hose cabinet located in the Day Hospital Corridor within Unit 31-A so that the door will close securely with the latch. — 6/25/10
Responsible Person:
[redacted] Director of Operations,
[redacted], Operations & Maint. Supv

25. Remove a cabinet/shelving unit within Room #2336-Acute Clothing Room, located on Unit 52-A2 so that access can be obtained to the washer/dryer room. — 6/25/10
Responsible Person:
[redacted], Director of Operations,
[redacted]. Mech. Maintenance Superint.

26. Replace the lighting in the Janitor Closet, located on Unit 52-A1. — 6/25/10
Responsible Person:
[redacted] Director of Operations,
[redacted] Operations & Maint. Supv
[redacted] Director of Operations,
[redacted] Operations & Maint. Supv

27. Repair or replace the lighting in the Food Storage space located in Unit 31-A to maintain — 6/25/10

proper illumination.
Responsible Person:
[redacted] Director of Operations,
[redacted] Operations & Maint. Supv

28. Clean and dust in Room #28-Office, located on Unit 53-A1, as well as maintain a log for regularly scheduled dusting of offices on the Unit. — 6/25/10
Responsible Person:
[redacted] Director of Operations,
[redacted]. Mech. Maintenance Superint.

29. Clean and dust the Electrical Closet located on Unit 31-A, as well as maintain a log for regularly scheduled cleaning of all Electrical Closets in the Hospital. — 6/25/10
Responsible Person:
[redacted] Director of Operations,
[redacted] Mech. Maintenance Superint.

30. Clean and dust the exhaust grills within Room #8- Public Toilet, located on Unit 43-D1, as well as maintain a log for regularly cleaning exhaust grills within all toilet rooms in the Hospital. — 6/25/10
Responsible Person:
[redacted] Director of Operations,
[redacted]. Mech. Maintenance Superint.

31. Clean and dust the ventilation grills within Room #2211-Clinics Department, Dentist, EKS, ObGyn, and Optical room, Located on Unit 42-A1 as well as maintain a log for regularly cleaning the ventilation grills for Room#2211. — 6/25/10
Responsible Person:
[redacted] Director of Operations,
[redacted] Mech. Maintenance Superint.

32. Clean the exhaust grills within all rooms located in Unit 43-A1 as well as maintain a log — 6/25/10

for regularly cleaning the exhaust grills for the Unit.
Responsible Person:
[redacted], Director of Operations,
[redacted]. Mech. Maintenance Superint.

The Governing Body will ensure that the facility has and uses sufficient resources to appropriately manage the facility and maintain a clean, safe environment. On 6/7/10 the Division Administrator directed the appointment of a standing Environment of Care Committee to be chaired by the Division's Assistant Administrator - Environment of Care Compliance. The Environment of Care committee members will include engineering, maintenance, operations. infection control, dietary and house keeping representatives. The committee will begin meeting by 6/25/10. The committee will meet at regular intervals and the chair shall directly report to the governing body. 6/25/10

Responsible Persons:
[redacted], BHD Administrator
[redacted] Director of Operations
[redacted], Operations Coordinator
[redacted] Assistant Administrator-
[redacted] of Care Compliance

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	524001		05/11/2010

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A 701	Continued From page 22 dust that the housekeeping staff indicated had not been cleaned for at least 12 months. 31. On May 6, 2010 at 11:48 am surveyor #18107 observed in the 42-A1 smoke compartment on the 2nd floor that in the 2211-Clinics Department, Dentist, EKG, ObGyn and Optical room, there was a build-up of lint and dust on ventilation grills. There was visible dust, up to 1/4" thick, hanging from the 15 return air grills in these rooms. 32. On May 6, 2010 at 3:30 pm surveyor #18107 observed in the 43-A1 smoke compartment on the 3rd floor that in the occupied spaces, the exhaust grills had a accumulation of dust that the housekeeping staff indicated had not been cleaned for at least 12 months.	A 701		
A 709	482.41(b) LIFE SAFETY FROM FIRE Life Safety from Fire This STANDARD is not met as evidenced by: Surveyor: 22219 Based on observation, staff interviews and review of maintenance records, the facility did not construct, install and maintain the building systems to ensure a life safety environment in the building to meet the minimum requirements of the 2000 Edition of the Life Safety Code for the "Existing Healthcare Occupancy" chapters of this code. The facility did not have a facility free of life safety deficiencies. This deficiency occurred in all of the 36 smoke compartments, and would affect all patients in the facility on the day of the survey, as well as staff and visitors. Findings include: On May 11, 2010 surveyor #18107 observed that the facility had the following life safety deficiencies: K12 (building type), K17 (corridor	A 709	**A709** The hospital will be constructed, arranged and maintained to ensure the safety of all patients, staff and visitors. The facility will provide a safe, clean and properly maintained environment in compliance with NFPA 101-Life Safety Codes (See A 701, A 726 and the K tags). The Governing Body will ensure that the facility has and uses sufficient resources to appropriately manage the facility and maintain a clean, safe environment. On 6/7/10 the Division Administrator directed the appointment of a standing Environment of Care Committee to be chaired by the Division's Assistant Administrator - Environment of Care Compliance. The Environment of Care committee members will include engineering, maintenance, operations, infection control, dietary and house keeping representatives. The committee will begin meeting by 6/25/10. The committee will meet at regular intervals and the chair shall directly report to the governing body.	6/25/10

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A 709	Continued From page 23 walls), K18 (corridor doors), K25 (smoke barrier walls), K27 (smoke barrier doors), K29 (hazardous rooms), K33 (stairwells), K38 (egress), K45 (redundant lighting), K51 (fire alarm), K56 (sprinklers), K62 (sprinkler inspections), K72 (egress obstructions), K75 (hazardous carts), and K147 (electrical). Please refer to the full description of the deficient practice at the cited K-tags.	A 709	Responsible Persons: [redacted] BHD Administrator [redacted] Director of Operations [redacted] Operations Coordinator [redacted] Assistant Administrator-Environment of Care Compliance See Plan of Correction on K-tags document, 41GC21	
A 726	482.41(c)(4) VENTILATION, LIGHT, TEMPERATURE CONTROLS There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This STANDARD is not met as evidenced by: Surveyor: 22219 Based on observation and staff interviews, the facility failed to have a ventilation system that was installed and properly maintained. This deficiency occurred in 3 of the 36 smoke compartments, and would affect all patients in the facility on the day of the survey, as well as staff and visitors. Findings include: 1. On May 7, 2010 at 1:53 pm surveyor #18107 observed in the 31-B smoke compartment on the 1st floor that in the #1102A-Storage room, proper ventilation could not be determined and was not provided a source of air supply. 2. On May 7, 2010 at 1:55 pm surveyor #18107 observed in the 31-B smoke compartment on the 1st floor that in the #1102B-Classroom, that there were no ventilation grills in the room and proper ventilation could not be determined. 3. On May 11, 2010 at 8:39 am surveyor #18107 observed in the 52-A2 smoke compartment on the 2nd floor that in the #2336A-Washer/Dryer	A 726	**A726** The facility will have a ventilation system that is installed and properly maintained. 1. Create the proper ventilation for Room #1102A-Day Treatment Storage and provide an adequate source of air supply. Responsible Person: [redacted] Director of Operations, Mech. Utilities Engineer 2. Create the proper ventilation for Room #1102B-Day Treatment classroom and provide an adequate source of air supply. A contract must be awarded to install the ductwork, which will require time for design, plan review, contract bidding and installation so the work will be completed by 12/1/2010. Responsible Person: [redacted] Director of Operations, Mech. Utilities Engineer	6/25/10 12/1/10

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A 726	Continued From page 24 Room, that the room had no fresh air supply with at least 2 fresh air changes per hour. 4. On May 11, 2010 at 8:40 am surveyor #18107 observed in the 52-A2 smoke compartment on the 2nd floor that in the #2336A-Washer/Dryer Room the dryer was not vented directly to the outside. Lint and dust were built up and in the corners and surface areas of the room. Handfuls of lint were observed behind the dryer at the floor. 5. On May 11, 2010 at 2:21 pm surveyor #18107 observed in the 53-A1 smoke compartment on the 3rd floor that in the #3322-31-Child & Adolescent Pantry that the hazardous exhaust vent that was previously attached to a kitchen hood was capped-off and not removed after being abandoned. 6. On May 11, 2010 at 2:33 pm surveyor #18107 observed in the 53-A1 smoke compartment on the 3rd floor that in the #3322-10-Child & Adolescent Inpatient Laundry Room that the ventilation to the space was not working because lint and dust were in the exhaust duct. These findings were confirmed by Staff CC and Staff DD.	A 726	3. Create the proper fresh air supply with at least 2 fresh air changes per hour within Room #2336A-Washer/Dryer Room, located on Unit 52-A2. A contract must be awarded to install the ductwork, which will require time for design, plan review, contract bidding and installation so work will be completed by 12/1. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Engineer 4. Create the proper venting directly outside for the dryer in Room #2336A-Washer/Dryer Room, located on Unit 52-A2, as well as removing all dust and lint from the room. A log will be maintained for regularly cleaning all dryers within the Hospital. A contract must be awarded to install the ductwork, which will require time for design, plan review, contract bidding and installation so the work will be completed by 12/1/2010. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Utilities Engineer 5. Remove the capped-off hazardous exhaust vent that was previously attached to a kitchen hood in Room #3322-31, located within Unit 53-A1. Responsible Person: [redacted] Director of Operations, [redacted] Operations & Maint. Supv 6. Clean lint and dust from the exhaust duct of Room #3322-10-Child and Adolescent Inpatient Laundry located on Unit 53-A1 so that proper ventilation is maintained as well as maintain a log for regularly cleaning Laundry room exhausts. Responsible Person: [redacted] Director of Operations, [redacted] Mech. Maintenance Superint.	12/1/10 12/1/10 7/25/10 6/25/10
A 747	482.42 INFECTION CONTROL The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Surveyor: 26711 Based on staff interviews and observations, and policy and procedure reviews, the hospital failed to provide a sanitary environment to avoid the	A 747		

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A 747	Continued From page 25 transmission of infections and communicable diseases and failed to have an effective and active infection control program for the prevention, surveillance, control, investigation and guidance to all areas/services in the hospital whether the services were provided directly by hospital staff or under contract. This failed practice would affect all patients, staff and visitors. Findings include: Based on interview, the Infection Control Practictioner (ICP) failed to be involved in the development and implementation of policies that govern the control of infections and communicable diseases throughout the hospital. (See A0748). Based on observation, review of the infection control log, and staff interview, the infection control practitioner failed to include all areas of the hospital in the identification, reporting, investigation and controlling infections. (A 0749) The cumulative effect of these systematic problems prevents the hospital from having an active and effective infection control program which is responsible for the prevention and transmission of infections and communicable diseases for all patients, staff and visitors.	A 747	The Governing Body will ensure that the facility has and uses sufficient resources to appropriately manage the facility and maintain a clean, safe environment. On 6/7/10 the Division Administrator directed the appointment of a standing Environment of Care Committee to be chaired by the Division's Assistant Administrator - Environment of Care Compliance. The Environment of Care committee members will include engineering, maintenance, operations, infection control, dietary and house keeping representatives. The committee will begin meeting by 6/25/10. The committee will meet at regular intervals and the chair shall directly report to the governing body. Responsible Persons: [redacted] BHD Administrator [redacted] Director of Operations [redacted] Operations Coordinator [redacted] Assistant Administrator-Environment of Care Compliance **A747** The hospital will provide a sanitary environment to avoid sources and transmission of infections and communicable diseases through the use of an active program for the prevention, control and investigation of infections and communicable diseases.	6/25/10 6/25/10
A 748	482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. This STANDARD is not met as evidenced by:	A 748	The hospital's infection control practitioner will ensure a clean and sanitary environment (See A 749). The hospital's infection control practitioner will develop and implement a hospital-wide infection control surveillance system (See A 748).	

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A 748	Continued From page 26 Surveyor: 22198 Based on interview, review of infection control surveillance data, infection control log, current policies, tour observations, and interviews, the Infection Control Practitioner (ICP) failed to provide guidance to all hospital departments regarding proper sanitary and infection control practices. This failed practice could affect all patients, staff and visitors. Findings include: On 05/04/10 between 8:00 a.m. and 9:25 a.m. Surveyor #22198 along with Behavioral Health Division (BHD) Administrator (also a dietitian) J and Aviands Lead O (contracted service) toured the onsite dietary areas defined as "dishwashing" area, "food set up" area , "dry storage unit", and the off-site kitchen and storage areas. (See A749 for details). BHD Administrator (also a dietitian) - J and Aviands Lead O confirmed to Surveyor #22198 that the hospital's ICP-S does not provide oversight or guidance in the dietary department, and acknowledged the need for infection control (IC) oversight. On 05/05/10 between 8:00 a.m. and 9:00 a.m. Surveyors #22198 and #18107 along with BHD Administrator J, Utilities Engineer CC, Operations Coordinator V, ICP S and Clothing Supply Clerk II - GG conducted interviews, tour and observation of the 2 Laundry areas defined by the hospital. (Reference A 749 for specific details). Clothing Supply Clerk II - GG confirmed ICP -S did not provide oversight or guidance in the laundry department.	A 748	The Governing Body will ensure the hospital has an active and effective infection control program responsible for prevention, surveillance, control, investigation and guidance to all areas/services in the hospital. The Governing Body will ensure that the facility has and uses sufficient resources to appropriately manage the facility and maintain a clean and sanitary environment. On 6/7/10 the Division Administrator directed the appointment of a standing Environment of Care Committee to be chaired by the Division's Assistant Administrator - Environment of Care Compliance. The Environment of Care committee members will include the infection control practitioner. The committee will begin meeting by 6/25/10. The committee will meet at regular intervals and the chair shall directly report to the governing body. Responsible Persons: [redacted] Administrator [redacted] Infection Control Preventionist, [redacted] Acute Inpatient Administrator, [redacted] Crisis Services Administrator, [redacted] Associate Administrator – Environment of Care Compliance **A748** ICP will provide guidance to and surveillance of all hospital departments regarding proper sanitary and infection control practices. The Infection Control Committee and the ICP will monitor and participate in the establishment of techniques and systems for the control of infections and communicable diseases as evidenced by:	6/25/10 6/25/10

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A 748	Continued From page 27 On 05/05/10 between 10:00 a.m. - 11:00 a.m. Surveyors #22198 and #18107 along with Behavioral Health Division (BHD) Administrator J, Utilities Engineer CC, Materials Distribution JJ, Materials Distribution Supervisor KK, Operations Coordinator V, and Infection Control Nurse Practitioner (ICP) - S conducted interviews, a tour and observations of the Central Supply area. (Reference A749 for specific details). Materials Distribution JJ confirmed the Central Supply department does not contact manufacturers to identify sterile products "shelf life" if it does not have an expiration date on it. JJ told Surveyor #22198 that the hospital used an "event related sterility" process, and explained that if the sterile package is not opened and is not visibly damaged, it remains good until opened. ICP S confirmed this protocol. Sterile packages not having expiration dates were identified on tour (sterile wound dressing change packages). On 05/04/10 at 3:00 p.m. Crisis Director C provided Surveyor #22198 with a policy identified as the " Event Related Sterility Maintenance" policy. This policy had no policy number and failed to identify the date of policy induction. This was confirmed by C. On 05/06/10 at 9:00 a.m. Surveyor #22198 and ICP - S conducted an interview and review of the materials (including the policy) about event related sterility maintenance. ICP S acknowledged the policy was not included in the Infection Control (IC) policy and procedure (P&P) list, it was not numbered, it failed to provide guidance as to proper procedures to ensure products remain sterile, and was developed by an Internet resource that was not a nationally	A 748	• The Infection Control Committee met with all departments on 06/08/10 to discuss the need for house-wide IC surveillance. • Each department in collaboration with the infection control practitioner will establish at least biannual environmental surveillance procedures by 06/25/10. • Each department will develop and present IC environmental surveillance QA Reports to the IC Committee. • Each department will collaborate with the ICP in the development of a department risk assessment tool and present the tool to the IC committee for review. • The IC Committee will review the House-wide Surveillance Policy and Procedure developed by the ICP at the July 2010 IC Committee meeting. Responsible Person: [redacted] Infection Control Preventionist **Central Supply**: Central Supply will have a system in place to monitor all clean and sterile supplies using expiration dates by 06/25/10. Vendors will be contacted by Central Supply Staff to obtain expiration dates on products that do not have them by 06/25/10. Central Supply supervisor will change the Central Supply guideline book into a Central Supply policy and procedure book, with policies being numbered by 6/25/10. Beginning 6/1/10, a cleaning logbook was initiated. Floors will be swept once per week; floors will be wet mopped once every 2 weeks; shelves will be dusted once per month. Employee will initial and date log books each time these tasks are completed.	6/25/10

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A 748	Continued From page 28 accepted standard of practice. ICP S confirmed to Surveyor #22198 on 05/05/10 at 10:00 a.m. that S does not currently provide surveillance or guidance to the central supply department. S told Surveyor #22198, that the hospital had never asked S to provide IC expertise, guidance or surveillance to any other department aside from the in-patient units. On 05/05/10 between 11:15 a.m. and 12:15 p.m. Surveyors #22198 and #18107 along with Behavioral Health Division (BHD) Administrator J, Utilities Engineer CC, Materials Distribution JJ, Materials Distribution Supervisor KK, Operations Coordinator V, Mechanical Maintenance Superintendent (MMS) - W, Clean Power District Manager - X and Clean Power Site Manager - Y conducted interviews, policy reviews, tour and observations. (Reference A701 for specific details). Mechanical Maintenance Superintendent (MMS) - W, Clean Power District Manager - X and Clean Power Site Manager - Y provided Surveyor #22198 with a copy of the Policy used within the hospital entitled " Personnel Policy and Safety Manual ". W, X and Y confirmed to Surveyor #22198, this was the only policy the department had to define IC standards and safety, however acknowledged that this was a Clean Power policy, based on their needs, and not a hospital policy based on hospitals needs with oversight from IC. MMS W confirmed their entire department is not provided oversight from ICP S, even though housekeeping is responsible for the clean and sanitary environment of the whole hospital.	A 748	All cardboard/outside shipping boxes will be removed from Central Supply and be replaced by plastic containers by 6/25/10. A HEPA air cleaner was purchased and placed in Central Supply on 5/12/10 to help maintain a clean environment. To ensure ongoing compliance, the Infection Control Practitioner (ICP) will conduct inspection rounds at least biannually in Central Supply. A checklist for the rounds will be developed in conjunction with the ICP. 2010 established by 06/25/10. Responsible Person: [redacted] Infection Control Preventionist, [redacted] Director of Operations, [redacted], Store Room Supervisor	

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A 748	Continued From page 29 On 05/05/10 at 10:00 a.m. ICP -S confirmed to Surveyor #22198 that S does not currently provide surveillance or guidance with policies and procedures for all hospital departments. Surveyor: 26711 Finding by Surveyor #26711: An interview with Surveyor #26711 and ICP S was completed on 5/4/10 at 9:30 a.m. ICP S provided Surveyor #26711 with surveillance tools and an infection control log that did not include data on all ancillary hospital departments, such as i.e.: kitchen, housekeeping, laundry, pharmacy, and central supply. ICP S confirmed that surveillance is done only on inpatient units.	A 748		
A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Surveyor: 26711 Based on observation and staff interviews and review of standards of practice, the hospital failed to ensure a clean and sanitary environment. Environmental tours reflect poor housekeeping, uncleanable work surfaces, mold, and unsanitary kitchen and laundry areas. This deficiency occurred in all of the 36 smoke compartments, all inpatient units, and would affect all patients in the facility on the day of the survey, as well as staff and visitors. Findings include:	A 749	**A749** A749 – 482.42(a)(1) INFECTION CONTROL See Attachment 1	

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A 749	Continued From page 30 According to the 2007 Guidelines for Isolation Precaution: Preventing Transmission of Infectious Agents in Healthcare Settings, the following standards apply to hospitals: 1.B.3.e. Vectorborne transmission of infectious agents from mosquitoes, flies, nats, and other vermin can occur in healthcare settings. 11.1 Environmental measures. " Cleaning and disinfecting, non-critical surfaces in patient-care areas are part of standard precautions. The cleaning and disinfection of all patient-care areas is important for frequently touched surfaces, especially those closest to the patient, that are most likely to be contaminated (e.g., bedrails, bedside tables, commodes, doorknobs, sinks, surfaces and equipment in close proximity to the patient) " . " In all healthcare settings, administrative, staffing and scheduling activities should prioritize the proper cleaning and disinfection of surfaces that could be implicated in transmission " . 11.K Textiles and laundry. " When laundering occurs outside of a healthcare facility, the clean items must be packaged or completely covered and placed in an enclosed space during transport to prevent contamination with outside air or construction dust that could contain infectious fungal spores that are at risk for immunocompromised patients " . According to the Centers for Disease Control and Prevention (CDC), Laundry: Washing Infected Material, " Clean linen should be handled, transported, and stored by methods that will ensure its cleanliness " . CDC, Facts about Stachybotrys chartarum and	A 749	A749 – 482.42(a)(1) INFECTION CONTROL See Attachment 1	

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A 749	Continued From page 31 Other Mold: " What are the potential health effects of mold in buildings and homes? " Some people are sensitive to molds. " These people may experience symptoms such as nasal stuffiness, eye irritation, wheezing, or skin irritation when exposed to molds ". "Immunocompromised persons and persons with chronic lung diseases like COPD are at increased risk for opportunistic infections and may develop fungal infections in their lungs ". VI.C.2. Of the 2007 Guideline for Isolation Precaution: Preventing Transmission of Infectious agents in Healthcare Settings. " Lower dust levels by using smooth, nonporous surfaces and finishes that can be scrubbed, rather than textured material (e.g., upholstery). Wet dust horizontal surfaces whenever dust detected and routinely clean crevices and sprinkler heads where dust may accumulate ". FDA 2005 FOOD CODE- U. S. Department of Health and Human Services 6-201.11 Floors, Walls, and Ceilings. Except as specified under § 6-201.14 and except for antislip floor coverings or applications that may be used for safety reasons, floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are SMOOTH and EASILY CLEANABLE. 6-201.12 6-501.111 Controlling Pests. The presence of insects, rodents, and other pests shall be controlled to minimize their presence on the PREMISES by: (A) Routinely inspecting incoming shipments of FOOD and supplies; (B) Routinely inspecting the PREMISES for evidence of pests;	A 749	A749 – 482.42(a)(1) INFECTION CONTROL See Attachment 1	

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A 749	Continued From page 32 (C) Using methods, if pests are found, such as trapping devices or other means of pest control as specified under §§ 7-202.12, 7-206.12, and 7-206.13; and (D) Eliminating harborage conditions. 6-501.11 Repairing. PHYSICAL FACILITIES shall be maintained in good repair. 6-501.12 Cleaning, Frequency and Restrictions. (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. (B) Except for cleaning that is necessary due to a spill or other accident, cleaning shall be done during periods when the least amount of FOOD is exposed such as after closing. 4-202.11 Food-Contact Surfaces. (A) Multiuse FOOD-CONTACT SURFACES shall be: (1) SMOOTH; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections; (3) Free of sharp internal angles, corners, and crevices; (4) Finished to have SMOOTH welds and joints. 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. By Surveyor #18107: Tour by Surveyor #18107 began on May 3, 2010 at 2:15 PM through May 7, 2010 at 1:55 PM and on May 11, 2010 from 8:20 AM to 2:59 PM.with Staff CC (Mech.Util.Engr.), and Staff DD (Oper.&	A 749	A749 – 482.42(a)(1) INFECTION CONTROL See Attachment 1	

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A 749	Continued From page 33 Maint.Sprvsr.). All observations were confirmed by Staff CC and Staff DD. 1. On May 11, 2010 at 8:20 am surveyor #18107 observed in the 52-C1 smoke compartment on the 2nd floor, in the #2309-Linen Room, a portion of the wall was damaged and in need of repair. Surveyor observed dark stains running down the wall from the top at several locations. 2. On May 4, 2010 at 2:02 pm surveyor #18107 observed in the 32-A2 smoke compartment on the 2nd floor in the #33-Office Toilet room that the toilet was not functioning. 3. On May 11, 2010 at 8:25 am surveyor #18107 observed in the 52-C1 smoke compartment on the 2nd floor that in the #2309-Clean Linen Room the floor under the storage racks at the perimeter of room and pipes in corners of the room were dirty and dusty. Clean towels were located on the dirty floor under all open perimeter metal storage shelving units. 4. On May 11, 2010 at 8:30 am surveyor #18107 observed in the 52-C1 smoke compartment on the 2nd floor that in the #2309-Linen Room had exposed mechanical ducts that were dusty and dirty. There was no washable and cleanable ceiling in the clean linen room. 5. On May 11, 2010 at 9:03 am surveyor #18107 observed in the 52-A2 smoke compartment on the 2nd floor that in the #2336-Acute Clothing Room there was dust and dirt on the floor and around the storage shelves located next to the door to the washer /dryer room. 6. On May 6, 2010 at 10:48 am surveyor #18107 observed in the 43-D1 smoke compartment on the 3rd floor that in the #8-Public Toilet the exhaust grills had a accumulation of dust that the housekeeping staff stated had not been cleaned for at least 12 months.	A 749	A749 – 482.42(a)(1) INFECTION CONTROL See Attachment 1	

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A 749	Continued From page 34 7. On May 11, 2010 at 9:14 am surveyor #18107 observed in the 42-B2 smoke compartment on the 2nd floor that in the #2308-Central Supply/General Distribution Room clean and soiled areas were inter-mixed for storing items. Surveyor #:26711: PHARMACY: During a tour of the pharmacy area on 5/3/10 at 11:25 a.m. accompanied by Pharmacist H, the following were observed and confirmed with Pharmacist H: 1. Ceiling vents had a build up of dust/debris in them. 2. There is evidence of water damage to several ceiling tiles in the back of the stock supply area. 3. The vent above the stock supply cart has a build up of a black substance. INPATIENT UNIT A: A tour of acute inpatient unit A was conducted on 5/3/10 at 3:00 p.m. accompanied by Administrator D, Registered Nurse (RN) I, and Manager EE and who confirmed these observations: 1. Room #5, a storage room for patient clothing, had bags of clothing and debris on the floor. 2. Room #9, a soiled utility room, had the following clean items found in the cabinets: legs to wheel chairs, clean mop heads, two straight jackets. A mat for placing on the floor along side a bed, was also in this room, and according to Administrator D, it did not belong there. 3. Laundry room, the wall behind the wash machine was damaged from the floor to approximately 6 inches up from water damage and the wash machine was standing in a puddle of water which creates the potential for mold to occur. 4. Room #37 had black mold on the floor in the	A 749	A749 – 482.42(a)(1) INFECTION CONTROL See Attachment 1	

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A 749	Continued From page 35 shower (confirmed by RN I) 5. Room #36 had a porous surface at the shower threshold rendering it a non-cleanable surface. 6. Room #28, the kitchenette; a lower cabinet to the left of the refrigerator was dirty on the inside. It contained open and undated chocolate milk which creates a potential for contamination. The freezer had a brown, sticky substance on the floor. 7. Room #25 had a vinyl couch with non-intact cushions, rendering them non-cleanable. Ceiling tiles outside of room #25 were non-intact. INPATIENT UNIT B: A tour of acute inpatient unit B was conducted on 5/3/10 at 3:40 p.m. accompanied by Administrator D, Registered Nurse (RN) I, and Manager EE and who confirmed these observations: 1. The soiled utility room had a box of clean hemoccult (a test to check for blood in stool) cards in a cupboard. 2. Rooms #38, 29, and 28 had a porous surface at the shower threshold rendering it a non-cleanable surface. 3. Room #29 had a container to catch urine sitting on the floor under the toilet. According to Administrator D that was not an acceptable place to store the container. INPATIENT UNIT C: A tour of acute inpatient unit C was conducted on 5/5/10 at 9:15 a.m. accompanied by Administrator D, Registered Nurse (RN) I, and Manager EE who confirmed these observations: 1. Eight rooms (#1, 7, 26, 30, 35, 36, 37, and 38) had a porous surface at the shower threshold rendering them non-cleanable surfaces. 2. Room #1 had cracked tile in the bathroom, rendering it a non-intact surface for cleaning.	A 749	A749 – 482.42(a)(1) INFECTION CONTROL See Attachment 1	

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A 749	Continued From page 36 3. Room #3 had water damage to the wall by the water fixtures in the bathroom creating a potential for mold. 4. Room #7 had breaches in the paint on the wall exposing the drywall and rendering it a non-cleanable surface. 5. Room #26, a seclusion room, had breaches in the paint on the ceiling exposing the drywall rendering it a non-cleanable surface. 6. Room #29, another seclusion room which was unoccupied, had a dirty washcloth left in the bathroom after the room had been cleaned. 7. Room #28, the kitchenette, had an opened juice bottle in the refrigerator that was not dated. INPATIENT UNIT D: A tour of acute inpatient unit D was conducted on 5/5/10 at 10:30 a.m. accompanied by Administrator D, Registered Nurse (RN) I, and Manager EE who confirmed these observations: 1. Four rooms (#1, 33, 35, and 36) had a porous surface at the shower threshold rendering them non-cleanable surfaces. 2. Room #35 had cracked tiles under the toilet, rendering them non-intact for cleaning. 3. Three rooms (#33, 34, and 36) had a build up of a black gummy substance, that RN I was able to remove with a paper towel and some pressure. This substance was built up in the edges along the sink base and in the corners of the bathroom. 4. Room #25 had a vinyl cushioned chair in which the vinyl was not intact, making the surface non-cleanable. 5. The housekeeping room had breaks in the integrity of the paint on the wall above the hopper making this area a non-cleanable surface. The room was generally dirty with dirty floors, dirty walls, scattered debris on the floor, and breaks in the integrity of the walls. There were also	A 749	A749 – 482.42(a)(1) INFECTION CONTROL See Attachment 1	

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A 749	Continued From page 37 beverage cups on top of a cabinet used to store supplies, one of which contained warm coffee. ON-SITE KITCHEN: On 5/4/10 between 8:00 a.m. and 9:30 a.m. Surveyor #22198 toured the on-site dietary areas defined as " dishwashing " area, " food set up " area, and " dry storage " area, with Behavioral Health Division (BHD) Administrator J (also a dietician), and Aviands Lead O (contracted services) who confirmed these observations: 1. No separation of clean and dirty for the following: the routing of dishes, placement of clean carts next to garbage cans, transport carts for clean trays had dirty trays on it. 2. The ceiling was a non-washable surface. 3. Door #2 of the dishwashing machine was leaking due to a missing rivet. 4. There was no sign on the garbage disposal to identify it as being out of order. The disposal had old food remaining in it and smelled foul. Fruit flies were noted throughout the dishwashing area. 5. The mounted wall fan, on the side where the clean dishes come out of the dishwasher, was covered in dust that was adhered to the fan blades and surfaces. Aviands Lead O confirmed the dish room was not on a cleaning schedule. FOOD SET-UP AREA: 1. The exterior of garbage cans were covered in food and liquid drippings that were also covered in dust and dirt debris. 2. All of the food storage and distribution carts (Camro carts) that were used to transport food from the kitchen area to the in-patient units were cracked creating a potential for cross-contamination. Large chunks on the	A 749	A749 – 482.42(a)(1) INFECTION CONTROL See Attachment 1	

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A 749	Continued From page 38 insulation and exterior were missing from 3 of the carts. BHD J confirmed the Camro carts could not function properly with these damages. 3. All Camro carts that are used to prepare and transport food were dirty inside, noting old food debris on the interior doors, the interior sides and at the bottom. 4. Walk in refrigerator #1 had food debris on the floors and interior doors. 5. Walk in Refrigerator #2 contained clean and dirty carts and racks, dry foods (boxes of cereal). Aviands Lead O and BHD J confirmed that the kitchen staff was using the refrigerator as storage, however this was not an acceptable practice. 6. The small freezer ' s exterior was dirty, the interior contained crumbs and food drippings. 7. Fruit flies were in the area and throughout the food preparation area. Aviands Lead O confirmed the food set up room was not on a cleaning schedule. Aviands Lead O told Surveyor #22198 that Aviands was a contracted service, and Lead O was unaware the contracted service was responsible for maintaining the cleaning of the kitchen area. DRY STORAGE AREA: 1. Food items and non-food items were intermingled together in the same area. There was no separation of clean and dirty or edible and non-edible items which creates an environment for food contamination. . 2. The dry storage room contained an ice machine. The floor under the ice machine had a green tint to it. Aviands Lead O and BHD J explained to Surveyor #22198 the green floor was possibly condensation stain from the copper	A 749	A749 – 482.42(a)(1) INFECTION CONTROL See Attachment 1	

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A 749	Continued From page 39 pipes that ran to the ice machine. Following the pipes along the wall of the dry storage area, was a large table that had a cloth covering it. The cover of the table was directly under the ice machine pipes, and was wet and discolored which creates an environment for mold to develop. Aviands Lead O confirmed the dry food storage room was not on a cleaning schedule and should not be used for all purpose storage. OFF-SITE KITCHEN: On 05/04/10 at 9:30 a.m. - 10:15 a.m. Surveyor #22198 along with BHD Administrator J, Aviands Lead O and Food Service Assistant Director Q toured the off- site kitchen (food production) and storage area. 1. A floor drain next to the large rotating Baxter oven did not fit properly and was sitting at an angle which creates an environment for contaminates from the drain to escape into the kitchen. 2. Ceiling tiles above two "Chill Blast" machines did not fit properly and left gaping open areas. One tile was hanging down onto the top of the second Chill Blaster. A ceiling light fixture cover had dark liquid sitting inside of it. Aviands Lead O and BHD J thought the fluid inside a light fixture was caused by a ceiling leak. 3. The milk cooler had cracked floors, and rusting walls, and chipped ceiling exposing rust. Aviands Lead O confirmed the milk cooler could not be effectively cleaned in this condition. The milk cooler had areas around the exterior that could not be cleaned because storage racks and half walls prevented staff from getting into the area. 4. Large clouds of steam were observed coming	A 749	A749 -- 482.42(a)(1) INFECTION CONTROL See Attachment 1	

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A 749	Continued From page 40 out of the dishwasher when dishes enter to be cleaned. The ceiling just above this area had a vent that had black debris hanging off of the vent and the surrounding ceiling area. Aviands Lead O and BHD J acknowledged with the continuous moisture (steam) there was potential for the black debris to be mold. 5. The dishwasher exterior was not on a cleaning schedule and it was observed to have corrosion build up around the pipes and temperature gages. Dust and dirt were on the surfaces of the dishwashing machine. Dirt and cracked tiles were under the dishwashing machine. 6. Seventeen large dusty Carbon Dioxide (CO2) cylinders were sitting in the corner of the kitchen. This area was identified as the " clean area " where the dishes come out of the dishwasher after being sanitized. The CO2 cylinders were identified by Aviands Lead O and BHD J as cylinders from an old fire suppression system no longer used, however were maintained in this area for storage purposes. 7. On the second floor Freezer #2 had cracked floors and rusting walls and ceiling noted by chipping metal and exposed rust. Aviands Lead O confirmed these surfaces could not be effectively cleaned in this condition. There was also ice build up just outside the freezer door. LAUNDRY: A tour of the laundry was completed on 05/05/10 between 8:00 a.m. and 9:00 a.m. Surveyors #22198 and #18107 along with BHD Administrator J, Utilities Engineer CC, Operations Coordinator V, Infection Control Nurse Practitioner (ICP) - S and Clothing Supply Clerk II - GG conducted interviews, tour and observation of the 2 Laundry areas defined by the hospital.	A 749	A749 – 482.42(a)(1) INFECTION CONTROL See Attachment 1	

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A 749	Continued From page 41 MAIN LAUNDRY: 1. Five large wheeled carts were observed outside the main laundry room. Clothing Supply Clerk II - GG explained to Surveyor #22198 that the laundry is a contracted service. The 5 large carts were covered with a thin transparent plastic that resembled a garbage bag. Three of the five large cart covers were torn which allowed the clean laundry exposed to dirt in the hallway which was used by maintenance, housekeeping, laundry and kitchen staff and equipment. 2. Cloth curtains were used to cover the laundry shelves that held excess clean laundry, however the curtains did not have a scheduled or documented cleaning rotation. 3. Five dirty shipping boxes were kept on the same shelves as the clean laundry. Clothing Supply Clerk II - GG explained to Surveyor #22198, that the boxes were Christmas decorations, and they had no where else to store them. GG acknowledged that storage should not be on clean laundry shelves. 4. The main laundry room kept their cleaning supplies (vacuum, mop and bucket) in this room, not in a separate closet. The laundry employee's bathroom is also in this room and the door was kept open. SECOND LAUNDRY ROOM (ACUTE IN-PATIENT CLOTHING): 1. The yellow walls in this room were streaked with brownish stain. Clothing Supply Clerk II - GG or Utilities Engineer CC confirmed this was from leaking. Utilities Engineer CC explained because of the location of this laundry room, when heavy snow melts and heavy rains fall, this room is prone to having water leaking from the ceiling and down the walls. This creates an environment for mold.	A 749	A749 – 482.42(a)(1) INFECTION CONTROL See Attachment 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	524001		05/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILWAUKEE CTY BEHAVIORAL HLTH DIV	9455 W WATERTOWN PLANK RD MILWAUKEE, WI 53226

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A 749	Continued From page 42 2. A bucket was identified to catch rain water. 17 shelving units had large towels tucked under them to prevent the rain water from running out from under the shelves and into the main isles. 3. The ceiling, ceiling vents and exposed pipes were dusty and dirty. 4. The 17 large shelves, 2 tables, 4 smaller shelves and 2 coat racks were identified as maintaining clean in-patient clothing, however none of the clean clothing was covered, and the room was not on a cleaning schedule, by laundry or housekeeping staff. GG acknowledged that not all the shelving units were the required 4 to 6 inches off the floor, and some of the clothing was noted as hanging off the bottom shelf and on the floor. 5. A small enclosed room also had a washer and dryer used by the laundry staff to clean patient clothing, or laundry supplies, however the room was dusty and the dryer vent was dusty. Surveyor #22198 asked Clothing Supply Clerk II - GG how often the room was cleaned by laundry staff, and GG replied " when it is dirty ". Surveyor #22198 asked Clothing Supply Clerk II - GG how often the room was cleaned by housekeeping staff, GG replied " never ". BULK STORAGE (HARDWARE ROOM): On 05/05/10 between 10:00 a.m. - 11:00 a.m. Surveyors #22198 and #18107 along with BHD Administrator J, Utilities Engineer CC, Materials Distribution JJ, Materials Distribution Supervisor KK, Operations Coordinator V, and ICP S conducted interviews, tour and observations. These findings were confirmed in interview with the above while on tour: 1. Room # 2208 contained bulk storage, clean and dirty wheel chairs, 2 electrical clean Hoyer	A 749	A749 – 482.42(a)(1) INFECTION CONTROL See Attachment 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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A 749	Continued From page 43 scales, 1 electrical Hoyer lift, and 3 manual Hoyer lifts, 4 clean Geri Chairs, a clean Merry walker, and dirty red carts. Materials Distribution JJ, Materials Distribution Supervisor KK and ICP - S confirmed that there was no separation of clean and dirty. 2. On the ceiling it was noted stains above the storage shelves for Emergency Preparedness equipment that included the N95 respirator masks for the influenza pandemic. ICP - S confirmed that the N95 respirator masks for the influenza pandemic were damaged by water leakage. HOUSEKEEPING: On 05/05/10 between 11:15 a.m. and 12:15 p.m. Surveyors #22198 and #18107 along with Behavioral Health Division (BHD) Administrator J, Utilities Engineer CC, Materials Distribution JJ, Materials Distribution Supervisor KK, Operations Coordinator V, Mechanical Maintenance Superintendent (MMS) - W, Clean Power District Manager - X and Clean Power Site Manager - Y conducted interviews, policy reviews, tour and observations. These findings were confirmed in interview with the above while on tour: 1. The wheelchair cleaning room had no separation of clean and dirty. Dirty wheelchairs were wheeled in and out on the same path. The wheelchair cleaning room housed more than the wheel chair cleaner; old waste bins, containing garbage, were stored in this area. 2. Adjacent to the Wheelchair Cleaning Room was a room identified as "the battery charging" room. No separation between clean and dirty was identified in this room The room contained used floor cleaner and buffers, charging used batteries, and a washer and drier for towels and mop heads that were then stored on shelves within this room .	A 749	A749 – 482.42(a)(1) INFECTION CONTROL See Attachment 1	

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A 749	Continued From page 44 3. The second Housekeeping Room had co-mingling of clean and dirty storage. Barrels against the wall were intermingled and noted to have both clean and dirty mop heads and towels. Shipping boxes containing boxed tissue paper and toilet paper were open and in this room. Leaning against the open toilet paper boxes was an over the shoulder mount vacuum cleaner, that was dusty, and disassembled. A freshly cleaned mattress was being brought in as we toured the area, and was placed on a raw wood pallet, next to 12 other cleaned mattresses. Four shelves contained chemical cleaning supplies. REHABILITATION AREA: A tour of the Rehabilitation (Rehab) area was conducted on 05/03/10 from 2:30 p.m. - 3:30 p.m. with Rehab Coordinator MM. It was observed that clean and dirty linen was not kept separate. PSYCHIATRIC CRISIS CENTER: A tour of the Crisis Center was conducted with Crisis Administrator C and confirmed the following observations: Nursing staff used a Blood pressure cuff without cleaning it after use. Refrigerators in the Psychiatric Crisis Center (PCS) were not cleaned and were not on a cleaning schedule. Linen storage had cloth covers, not on a cleaning schedule. Blankets and pillows were hanging off the bottom shelf onto the floor.	A 749	A749 – 482.42(a)(1) INFECTION CONTROL See Attachment 1	

Wisconsin Department of Health Services – Centers for Medicare and Medicaid Services
CMS Form 41GC11 – Survey Date: 05/11/2010
Milwaukee County Behavioral Health Division

Attachment 1
A749 – 482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES

Hospital will ensure a clean and sanitary environment.

The ICP will develop and implement a house-wide infection control surveillance system to provide guidance to all departments and to maintain a clean, safe and well maintained environment for the control of infections and communicable diseases as evidenced by:

- The ICP held meetings on 6/8/10 with the following departments: Maintenance, Central Supply, Nursing, Dietary, Laundry/Linen, Clean Power and Pharmacy to discuss surveillance procedures.
- Each department will collaborate with the ICP to develop surveillance checklists and establish a schedule for at least biannual IC surveillance by 06/25/10.
- All Departments will have a representative on the IC Committee by 06/25/10.
- The ICP will continue membership on the Contract Service Committee to monitor IC issues.
- Each department will develop a QA IC surveillance report which will address deficiencies found and provide corrections. The report will be presented to the IC Committee.
- All departments over the next 6 months will collaborate with the ICP to develop a risk assessment tool to identify IC risks in their department. Departments will use the assessment results to implement measures that will reduce or correct identified risks.
- The ICP will have a written House-wide Surveillance Policy and Procedure developed by 06/25/10.
- A plan to instruct staff on the house-wide surveillance policy and procedure will be developed by 06/25/10.
- The ICP will meet with each department annually to review and/or revise departmental IC policies and procedures.
- All staff will complete a mandatory inservice by 6/25/10 to acknowledge their role in ensuring a safe, clean and well-maintained hospital.

Responsible Person: [redacted] Infection Control Preventionist
Correction Date: 6/25/10

In addition to the actions above, corrections have been made in the following areas/departments:

DIETARY

Dry Storage Area:
The organization and separation of the dry storage area was added to the cleaning schedule to be completed daily.

All Cleaning Schedules are monitored by supervisors daily. Monthly QA reports completed. Bi-Annual QA rounds will be done with county infection control practitioner or designee. A QA report will be generated and presented at the IC Committee meeting.

The dry storage area was thoroughly cleaned including any stains present on the floor. On May 5, 2010, a requisition was placed with BHD EES to wrap the pipe in the dry storage area and remove the table. On June 7, 2010, the cleaning and organization of the dry storage area was added to the cleaning schedule to be completed daily.

Food Set-up Area:
Garbage cans and their lids were added to the cleaning schedule to be completed three times per week.

All Cleaning Schedules will be monitored by supervisor daily and monthly QA reports completed. Bi-Annual QA rounds will be done with county infection control practitioner or designee. A QA report will be generated and presented at the IC Committee meeting.

All damaged food storage and distribution carts were removed from service.

As of June 4, 2010, two quotes were received from outside vendors to replace the Camaro carts. These quotes have been forwarded to BHD administration for review.

All carts received deep cleaning by 06/04/10. On June 4, 2010, food carts were added to the cleaning schedule to be completed daily.

The cooler walls, floor, and interior and exterior door was cleaned and sanitized. On 5/10/10, the cooler walls, floor, and interior and exterior door was added to the cleaning schedule to be completed daily.

Dirty racks and dry food were removed from the cooler.

On 5/10/10, verification that no dirty racks or dry food is present in cooler #2 was added to the cleaning schedule to be checked daily.

On May 21, 2010- the chest freezer was replaced with an upright freezer. On 5/10/10, freezer cleaning, sanitizing, and defrosting of the inside of the unit was added to the cleaning schedule to be completed once per month. In addition, cleaning of the exterior of the freezer was added to the cleaning schedule to be completed daily.

The food prep area was treated by pest control 6/3/10.

A'viands requested on 6/8/10 that the pest control vendor treat the kitchen and dish room area weekly until further notice.

On-Site Kitchen:
The EES Department contacted an outside vendor for proposal of reconfiguration of the on site kitchen in May 2010. The outside vendor visited the facility and submitted a schematic for review and approval. A schematic was submitted for review by both the EES department and A'viands representatives. The facility is currently awaiting an estimate to proceed forward.

A'viands staff confirmed on 6/8/10 that the dish machine rivet has been replaced.

A sign was placed on the garbage disposal indicating it was out of order. On May 10, 2010- the garbage disposal was cleaned thoroughly. Pest control treated the area on 6/3/10. On June 8, 2010, the cleaning and sanitation of the garbage disposal was added to a daily cleaning list. A'viands requested the pest control vendor treat the area on each weekly visit until further notice.

The mounted wall fans were cleaned throughout by A'viands staff. On 5/10/10, cleaning of the mounted wall fans was added to a bi-monthly cleaning schedule.

Off-Site Kitchen:
Requisition was placed on 6/9/10 to fix floor drains by 06/25/10.
Requisitions were placed on 5/14/10 fix ceiling tile by 6/25/10. The light fixture has been replaced.

Milk cooler was taken out of operation 5/28/10.

Requisition was placed on 6/9/10 to clean ceiling tiles by 06/25/10 and add to the county maintenance schedule.

The dishwasher exterior was added to cleaning schedule 6/7/10

The CO2 cylinders were removed on 5/27/10.

Requisition was placed on 6/9/10 to replace/repair ceiling, floor, and walls in freezer #2 by 10/1/10. All corrections involving significant labor, materials, potential bidding, capital approval, procurement will be prioritized and may require completion date beyond 6/25/10.

To ensure corrections are achieved and sustained all cleaning schedules are monitored by supervisors on a daily basis. Monthly QA reports will be completed. Bi-Annual QA rounds will be conducted with BHD infection control practitioner or designee. A QA report will be generated and presented at the IC Committee meeting.

Responsible Persons: [redacted] Infection Control Preventionist [redacted] Associate Administrator-Environment of Care Compliance, [redacted], A'viands, [redacted] Mechanical Maintenance Superintendent

LAUNDRY/LINEN

Laundry carts delivered from H.O.C. laundry will be inspected upon arrival for any tears in the plastic covering. If any tears are found they will be repaired immediately to insure coverage. The Clothing Supply Clerks were put in charge of quality assurance of this 6/2/10. As of 6/7/10, use of reusable cart covers is being considered, pending price quotes. Cart covers will be ordered and in place by 9/1/10.

The cloth curtains covering laundry shelves are now on a cleaning schedule beginning 6/2/10 with initial cleaning of these curtains completed by 6/25/10. A department policy will be initiated by 6/25/10.

The holiday decorations were removed from the linen room and put into storage on 6/3/10.

Cleaning supplies were removed from the linen room on 6/7/10 and are now stored in a locked cabinet in the laundry room 2336A.

As of 5/6/10, the door to the bathroom within the Linen Room has a sign posted stating that the door must remain closed at all times. The Laundry Coordinator will monitor this practice.

The bucket and towels under the shelving units in the Clothing Room have been removed.

Laundry Coordinator met with Clean Power on 6/9/10 to coordinate cleaning of the ceiling, ceiling vents and exposed pipes. A cleaning schedule will be in place by 6/25/10.

Curtains are being made to cover shelving units and a policy will be written and implemented by 6/25/10.

Laundry Coordinator met with Clean Power on 6/9/10 to coordinate a cleaning schedule for this room and have it place by 6/25/10.

The Clothing Supply Clerks will monitor that linen is properly on the shelves.

Laundry Coordinator met with Clean Power on 6/9/10 to coordinate cleaning of the washer/dryer room and develop a schedule of cleaning. Laundry Coordinator will meet with Maintenance to develop a cleaning schedule for the dryer vent by 6/25/10.

To ensure ongoing compliance:

- The ICP will collaborate with the Laundry Department Coordinator to create checklists and to establish a schedule of inspection. QI Inspection Reports will be completed and reported to the IC Committee.
- The Laundry/Linen Department will have a representative on the IC Committee by 06/25/10. The Laundry Coordinator attended the IC Committee meeting on 06/08/10.
- The ICP met on 06/08/10 with the Laundry Department Coordinator and staff to collaborate on infection control plans of correction.

Responsible Person: [redacted] Infection Control Preventionist, [redacted] Clothing Room Coordinator
Correction Date: 6/25/10

MAINTENANCE

Linen Room:
The Linen Room wall will be repaired and painted by 10/1/10. The Linen Room will have a washable ceiling installed. Because this work will require bidding out contracts, this work will be completed by October 1, 2010.* Maintenance Department will routinely monitor area to see if stains reoccur. On or before 06/25/10, the plumbers repaired the toilet.

Pharmacy: The damaged ceiling tiles have been replaced.

Inpatient Unit 43A:
The washing machine was replaced on 5/11/10. The wall will be repaired and painted. Ceiling tiles by room #25 will be replaced. Because this work will require bidding out contracts, this work will be completed by October 1, 2010.

Inpatient Unit C:
On 5/11/10, shower thresholds were deemed non-porous by inspector #18107.
On or before 6/25/10, the Maintenance Department will repair the ceramic tile.
Janitor closet walls will be repaired, cleaned, painted and clad with vinyl panels. Due to the number of walls requiring repair, this work will be completed by 10/1/10.
For room #7 and #26, painting work will be prioritized and completed by 10/1/10.*

Inpatient Unit D:
On 5/11/10, shower thresholds were deemed non-porous by inspector #18107.
On or before 6/25/10, the Maintenance Department will repair the ceramic tile in room 35.
Janitor closet walls will be repaired, cleaned, painted and clad with vinyl panels by 10/1/10.*
By 6/25/10, memo will be issued to Cleaning contractor that there will be no eating or drinking in janitor closets.

On-Site Kitchen:
A contractor will be hired to replace ceiling by 8/25/10.*

Dry Storage Area:
On or before 6/25/10, cleaning contractor will clean tile floor or make determination to have it replaced. Maintenance Department will install pipe insulation on water pipes to prevent condensation by 6/25/10. A protective curtain will be installed to separate the battery charging area from the adjacent area by 10/1/10.*

Second Laundry Room (Acute Inpatient Clothing):
Wall will be painted and repaired by 11/1/10.*
The Maintenance Department will be raising shelves to 4 inches or more above the floor on or by 6/25/10.

**All corrections involving significant labor, materials, potential bidding, capital approval and procurement will be prioritized and may require completion date beyond 6/25/10.*

To ensure corrections are achieved and sustained:

- Maintenance coordinators attended the IC Committee Meeting on 6/8/10 to review infection control concerns.
- Maintenance coordinator met with the ICP on 6/8/10 to collaborate on plans of correction and to discuss the importance of routine departmental monitoring, creation of checklists and environmental department surveillance, all of which will assist in maintaining a building that is clean and safe.

Persons responsible: [redacted] Infection Control Preventionist, [redacted] BHD EES, [redacted] BHD EES and [redacted] BHD EES

HARDWARE ROOM

Room 2208 Hardware Room will be divided into 2 areas: clean area and delivery preparation area. Clean area will hold all equipment that has been cleaned, tagged as having been cleaned, and covered until taken out for use. Items to be cleaned will be taken to Central Supply through the dirty entrance for cleaning and then stored in the Hardware Room. Overflow of supplies for Central Supply will be stored in the delivery preparation area of the Hardware Room. Supplies will be taken out of outside shipping cartons and stored in this area until ready for delivery. A sign will be placed on the entrance to the Hardware Room that states that no dirty items are to be placed in this room. Signage will also be placed inside the room to designate the clean area from the delivery preparation area. This will be completed by 6/25/10.

All dirty and broken items in the Hardware Room will be removed from the room by 6/25/10.

The Infection Control Practitioner or her designee will conduct at least biannual inspections of the Hardware Room. Central Supply personnel in conjunction with the ICP will establish a checklist for the hardware room and set 2010 inspection dates by 06/25/10.

Plastic pallets will replace all wooden pallets by 6/25/10.

Hardware Room will be cleaned and organized by 06/25/10.

On 6/8/10, a work order was submitted for repair of the leak in the Hardware Room ceiling with a completion date of 8/25/10.

All stained and damaged boxes and supplies in the Hardware Room will be discarded by 6/25/10.

A work order was issued on 6/8/10 for the floors in the Hardware Room to be cleaned by 6/25/10.

A cleaning schedule and log book will be started for the Hardware Room on 6/1/10 with cleaning done on the same schedule as in Central Supply.
Persons responsible: [redacted], Infection Control Preventionist, [redacted], Store Room Supervisor, [redacted], Director of Operations

Correction date: 6/25/10

CLEANPOWER/HOUSEKEEPING

On or before 06/25/2010, the pipes in the Clean Linen Room will be cleaned and the towels will be picked up. These areas will be routinely cleaned and monitored by Clean Power supervisor through the use of checklists to maintain cleanliness.
On or before 06/25/2010, the Linen Room exposed ducts will be routinely cleaned and monitored by the Clean Power supervisor through the use of checklists to maintain cleanliness.
On or before 06/25/2010, the Acute clothing room floor and surrounding area(s) will be routinely cleaned and monitored by Clean Power supervisor through the use of checklists to maintain cleanliness.
On or before 06/25/2010 3rd floor #8 public toilet, the exhaust grills will be routinely cleaned and monitored by Clean Power supervisor through the use of checklists to maintain cleanliness.

Pharmacy:
On or before 06/25/2010, all ceiling vents in the department will be routinely cleaned and monitored by Clean Power supervisor through the use of checklists to maintain cleanliness.

Inpatient Unit A:
Room #9 - On or before 06/25/2010, staff will be instructed that all items in Room 9 are considered dirty and need to be properly cleaned before use. Clean Power supervisor will monitor staff for compliance daily with routine inspections.
Room #37 – It was determined that the substance was dirt. This area was cleaned on 05/11/10.
Room #36 – The epoxy surface was deemed appropriate by Inspector 18107 as non-porous.
Inpatient Unit B:
Rooms #38, 29 and 28 – the epoxy surface was deemed appropriate by Inspector 18107 as non-porous.
Inpatient C:
The epoxy surface in the identified rooms was deemed appropriate by Inspector 18107 as non-porous.
Inpatient D:
It was determined by Inspector 18107 that the epoxy surface was non-porous.
On or before 06/25/10 the black, gummy substance build up will be routinely cleaned and monitored by Clean Power supervisor through the use of checklists to maintain cleanliness.
On or before 06/25/2010, Clean Power will receive instruction that there is to be no eating or drinking in janitor's closet and janitor's closets will be monitored on surveillance rounds.

Dry Food Storage Area:
On or before 06/25/2010, cleaning contractor will clean tile floor.

Housekeeping in Central Supply Storage Area:
Trash cans were removed.
Intermediate Plan: By 06/25/2010, cleaned wheelchairs will be placed on clean cart for delivery.
Long Term Plan: On or before 6/25/10, the department will research the feasibility of installing a circulation doorway for wheelchairs in the cleaning room.
On or before 06/25/2010, remove cleaning products, take cleaned mops and rags to a clean storage area rather than storing them in this room.
Notify cleaning contractor of clean/dirty division requirement. Divide up Clean Power storage room to make one side clean items and one side for dirty items on or before 6/25/10.
Remove wood pallets on or before 06/25/2010.

To ensure corrections are achieved and sustained
- Clean Power and Housekeeping coordinators attended the IC Committee Meeting on 6/8/10 to review infection control concerns.
- Clean Power and Housekeeping coordinators met with the ICP on 6/8/10 to collaborate on plans of correction and to discuss the importance of routine departmental monitoring, creation of checklists and environmental department surveillance. All of which will assist in maintaining a building that is clean and safe.

Responsible person: [redacted] Infection Control Preventionist, [redacted] Contract Services Coordinator, [redacted] Mechanical Maintenance Superintendent, [redacted] Cleanpower Supervisor

NURSING DEPARTMENT

43A:
On 5/3/10, bags of clothing and debris removed from floor in Room 5.
On 5/3/10, all items removed from Room 9: legs to wheelchairs, clean mop heads, vests, falls prevention mat.

On 5/3/10, chocolate milk removed and discarded. Freezer cleaned. Brown, sticky substance removed and lower cabinet to the left of the refrigerator was cleaned.
On 5/3/10, vinyl couch was removed.

43B:
On 5/3/10, clean hemocult kit was removed from dirty utility room. Instruction will be given on proper storage of equipment to staff by 6/25/10.
On 5/3/10, urine container removed from room #29.

43C:
On 5/3/10, dirty washcloth was immediately removed.
On 5/3/10, opened juice bottle was removed from refrigerator in kitchenette.

On May 17th, 2010 a meeting was held with key management staff and dieticians from A'viands (contract vendor) regarding procedures for labeling/dating and storage of snacks and nourishments to the acute inpatient units.
Cheryl Schloegl and Katie Stecker were in attendance from BHD Department of Nursing.
Procedures were discussed and will be presented at the Joint Practice Clinical Improvement Team Meeting on June 9, 2010.

PCS
On 5/5/10, staff was instructed to use 10% bleach wipes to clean cuffs between patient use. Blood pressure cuffs will be cleaned per manufacturer's recommendations.
On 5/5/10, refrigerators were cleaned and will be maintained per procedure.
On 5/5/10, blankets and pillows were removed from lower shelf to avoid contact with floor. Lower shelf was raised 4-6 inches above floor as a permanent corrective action.

Associate Administrator of Nursing [redacted] and NPC [redacted] attended infection control meeting on 06/08/10. They consulted with infection control practitioner related to plan of correction.

To ensure corrections are achieved and sustained, checklists will be created and used for documentation of environmental surveillance. They will be initiated by 6/16/10 for units 43A, 43B, 43C, and 43D. PCS will use checklists to ensure the maintenance of a clean and sanitary environment. Nursing is represented and will present a report to the IC Committee on unit environmental surveillance quarterly.

Responsible persons: [redacted] Infection Control Preventionist, [redacted] Associate Administrator of Nursing

PHARMACY

Pharmacy Director and ICP Will create a checklist to insure this is done quarterly.
To ensure corrections are achieved and sustained:

- Pharmacy coordinator attended IC Committee meeting on 6/8/10 to review infection control issues.
- Pharmacy coordinator met with ICP on 6/8/10 to collaborate on POC, and discuss checklists/environmental surveillance.

Responsible persons: [redacted] Roeschen's Pharmacy Director and Sue Schwegel, Infection Control Preventionist

REHABILITATION AREA
Staff will be instructed on the IC procedures and practices of maintaining separation of clean and dirty linen by 06/25/10.

Responsible persons: [redacted] Column Rehab and [redacted] Infection Control Preventionist
Completion Date: 6/25/10