

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/30/2012
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NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/30/12</p> <p>Facility Number: 000501 Provider Number: 155635 AIM Number: 100266260</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist Robert Sutton Trainee</p> <p>At this Life Safety Code survey, Grace Village Health Care Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. The original building consisting of halls 1, 2,3, 5 and the main dining room was surveyed with Chapter 19 Existing Health Care Occupancies.</p>	K0000		

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

TITLE

(X6) DATE

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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	<p>This one story facility was determined to be of Type III (211) construction and was fully sprinklered. The Rehabilitation addition to the facility completed in 2007 was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridors. Battery operated smoke detectors were installed in all resident rooms in the original building. The new Rehabilitation Unit had hard wired smoke detectors. The facility has a capacity of 89 and had a census of 73 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage and in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered were the hall 5 elevator room, a fire pump room,</p>			
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	<p>a detached garage used for storage of maintenance equipment and parts with the portion of the building used as a maintenance garage, and a detached shed used for storage of parts and lawn equipment.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/06/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
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K0025 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 4 penetrations in a smoke barrier wall was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for</p>	K0025	The twelve residents identified to have potential to be affected have not been affected. No other residents have been identified to be potentially affected. All unsealed penetrations in the smoke barrier will be filled with an approved material by a contracted specialist. Administration is currently seeking proposals from several companies who specialize in this type of work. The contractor will also inspect other areas of the facility to ensure all smoke barriers identified are completely sealed according to LSC 8.3.6.1. Maintenance personnel will be in-serviced on smoke barrier requirements and instructed on proper sealing of penetrations in the event that they would perform any work involving penetrations to smoke barriers or happen to note any unsealed barriers in the course of routine work. Facility maintenance personnel will inspect the smoke	11/27/2012			

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	<p>the specific purpose. This deficient practice could affect twelve residents in hall 5.</p> <p>Findings include:</p> <p>Based on observations with Director of Environmental Services on 08/30/12 at 3:25 p.m., the smoke barrier wall entering hall 2 had unsealed penetration around conduit measuring three fourths inch. This was acknowledged by the Director of Environmental Services at the time of observation.</p> <p>3.1-19(b)</p>		<p>barriers on a monthly PM schedule for the next 6 months to ensure no new penetrations have been made without proper sealing and that the sealing in existing penetrations remains intact. The results of the monthly inspections will be reviewed in the quarterly QA Committee meetings. If there are no issues of non-compliance found during the monthly inspections, the QA Committee may allow the inspections to continue on an annual basis. Otherwise, inspections will continue on a monthly basis and be reviewed again at the next QA Committee meeting. Administration requests an extension up to 11/27/12 to allow sufficient time for proposals to be obtained and work completed. Staff in the affected areas will be informed of the unsealed penetrations so that they can be better prepared in the event of a fire before the work is completed.</p>		

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K0038 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 7 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect 17 of 63 residents.</p> <p>Findings include: Based on observation with the</p>	K0038	<p>The current (and long practiced) procedure has been to inform visitors and cognitive residents of the code needed to exit the locked portion of the facility if they do not know it already. Administration has always felt that the importance of keeping residents with cognitive impairment safe from elopement outweighs the potential minor inconvenience of having residents without the need for that specific security measure to ask staff for the access code. To the best of our knowledge, all visitors have been able to leave and all residents who were cognitively able have been able to do so as well with the assistance of staff if necessary. Although we believe that the applicable code does not specify that the doors shall not be locked if there happen to be any residents who do not have a "clinical diagnosis" for that particular security measure, we have been informed that CMS has interpreted the guideline differently. And though it is not to be found in the written guidelines, it is our understanding that CMS has taken the stance that the keypad access system is permissible if the code (or a simple hint to the code) is posted. In order to comply with</p>	09/28/2012

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	<p>Director of Environmental Services on 08/30/12 during the tour from 12:50 p.m. to 3:40 p.m., all of the emergency exit doors, except the main entrance, were magnetically locked and could be opened by entering a code, but the code was not posted. Based on an interview with the Assistant Director of Nursing at 3:00 p.m., seventeen of the sixty three residents do not have a diagnoses requiring specialized security measures.</p> <p>3.1-19(b)</p>		<p>this unwritten standard, Administration will post a sign at each of the locked doors with a hint to the code that will enable all people who do not have a "clinical diagnosis" to exit without the need to obtain the code from staff. The code will be changed on a monthly basis and the hint will be "the current month and year". The code will be changed on the first day of each month by maintenance personnel. When the technician changes the code, he or she will verify that the sign with the hint is still posted. If a sign is ever found to be missing, it will be reported to the Director of Environmental Services who will ensure that a replacement sign is posted immediately. The QA Committee will review the results of these corrective actions during the next two quarterly meetings, but the monthly monitoring procedure will be ongoing.</p>		

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K0044 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect seventeen residents on the Hall 2 and any residents at the main nurses' station.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services on 08/30/12 at 2:05 p.m., there was a one and one half inch gap between the fire doors entering Hall 2 when they were closed.</p>	K0044	<p>The seventeen residents on Hall 2 and any residents near the nurse station identified to have potential to be affected have not been affected. All other fire doors were inspected and none of them were found to be outside of required specifications. No other residents have been identified to be potentially affected. The existing set of fire doors has been determined to be irreparable. Replacement doors have been ordered and have an anticipated ship date of 9/21/12. The doors will be installed by facility maintenance personnel according to proper specifications upon receipt. The replacement doors will be inspected on a weekly basis for 90 days and on a monthly basis thereafter. The results of the inspections will be reviewed in the quarterly QA Committee meetings. If there are any issues of non-compliance found during the inspections, adjustments will be made immediately and the QA Committee will require the inspections to continue on a weekly basis until reviewed again at the next meeting. Otherwise, inspections will continue on a monthly basis. Administration requests an extension up to 11/27/12 to allow for the possibility of unforeseen shipping</p>	11/27/2012

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	Based on an interview with the Director of Environmental Services at the time of observation, he confirmed these were fire doors and stated the doors were warped. 3.1-19(b)		delays and for adequate time for work to be completed. Staff in the affected areas will be informed of the gap in the existing fire doors so that they can be better prepared in the event of a fire before the work is completed.		

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K0048 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to provide a written plan that included the different types and the use of fire extinguishers provided in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a record review with the Director of Environmental Services on 08/30/12 at 12:50 p.m., the</p>	K0048	<p>No residents have been identified to have been affected by the cited deficiency. All staff are in-serviced on an annual basis on the types and uses of fire extinguishers in the building. In the few situations over the years that have warranted use of fire extinguishers, the staff responded each time appropriately and correctly according to their training. Wording will be added to the Emergency Manual to specifically describe the two types of fire extinguishers that are found in the facility and for what types of fires they are to be used. All staff will be informed of the modification to the Emergency Manual. The Director of Staff Development, or her designee, will review records to ensure that all staff have been in-serviced on the update to the Emergency Manual. The QA Committee will review the results of the monitoring at the quarterly QA Meeting and will re-evaluate the policy to ensure that the information regarding extinguishment of fires is up to date and accurate. If there are no concerns with non-compliance, the Committee will allow for monitoring to be conducted on an annual basis, otherwise it will continue on a quarterly basis.</p>	09/28/2012	

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	"Emergency Manual" did not address the types of fire extinguishers throughout the facility including the kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. This was confirmed by the Director of Environmental Services at the time of record review. 3.1-19(b)			

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K0050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 4 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Grace village Fire Drill Procedure Form" with the Director of Environmental Services on 08/30/12 at 12:10 p.m., actual fire drills were not conducted for the second shift of the first quarter 2012, second and third shifts for the second quarter of 2012, or the second and third shifts for the third and fourth quarters of 2011. Based on an interview with the Director of Environmental Services at the time</p>	K0050	<p>No residents have been affected by the deficiency cited. Administration wishes to note that fire drills were, in fact, conducted and were done so on a more frequent basis than required. They simply were not conducted according to the State's interpretation of the code. The facility drills in question were initiated by the drill leader announcing a fire in a certain location (in person rather than on the overhead page) and having staff in that area explain and/or demonstrate exactly what they need to do to respond. The fire drill procedure will be updated to require that they are initiated by an overhead page, utilizing a coded alert, and that staff physically respond in the same manner they would as with an actual alarm. A log will be kept of each of these drills to document the steps that were taken. The staff responsible for leading the drills will be instructed on the revised procedure. The Director</p>	09/28/2012

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	<p>of record review, he did not conducted an actual fire drill but instead did a walk thru question and answer session during the shifts listed above.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>of Environmental Services will monitor the logs to ensure that the drills have been conducted according to the revised procedure and according to the quarterly per shift frequency required. He will report the results of his monitoring to the QA Committee at its quarterly meetings for the next two quarters. The QA Committee will require continued quarterly monitoring if any instance of non-compliance is found.</p>		

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K0056 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 1 elevator equipment rooms in hall 5 in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice was not in a resident care area but could affect staff.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Environmental Services on 08/30/12 at 2:58 p.m., the hall 5 elevator equipment room lacked sprinkler coverage. This was</p>	K0056	<p>The citation correctly notes that the elevator machine room is not located in a resident care area, it is a service elevator, although certain staff do use said elevator. To date, no staff have ever been affected by the cited deficiency. A sprinkler head or permissible alternative will be installed to comply with this new requirement from CMS that became effective July 2012. Proposals are currently being obtained from several area companies that specialize in fire safety systems. The sprinkler head (or permissible alternative) will be inspected according to NFPA standards by a certified professional. The documentation of those inspections will be maintained in the office of the Director of Environmental Services (ES). The ES will provide a copy of the work order</p>	11/27/2012			

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	confirmed by the Director of Environmental Services at the time of observation. 3.1-19(b)		to the Administrator when the work and the inspections have been completed. The QA Committee will review the documentation to ensure the corrections are complete and that the annual inspections (monitoring) are being conducted as required. Administration requests an extension up to 11/27/12 in order to obtain the necessary proposals, secure a contract and have work completed. In order to maintain heightened fire safety awareness until the work is completed, all staff will be informed of the lack of an automatic sprinkler in the elevator machine room and reminded of the location of the nearest fire extinguisher.		

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K0130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure penetrations in 3 of 5 fire barrier walls were protected by an approved device designed for the specific purpose and capable of maintaining the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item</p>			K0130	<p>The residents identified to have potential to be affected have not been affected. No other residents have been identified to be potentially affected. All unsealed penetrations in the fire barrier will be filled with an approved material by a contracted specialist. Administration is currently seeking proposals from several companies who specialize in this type of work. The contractor will also inspect other areas of the facility to ensure all fire barriers identified are completely sealed according to LSC 8.2.3.2.4.2. Maintenance personnel will be in-serviced on fire barrier requirements and instructed on proper sealing of penetrations in the event that they would perform any work involving penetrations to fire barriers or happen to note any unsealed barriers in the course of routine work. Facility maintenance personnel will inspect the fire barriers on a monthly PM schedule for the next 6 months to ensure no new penetrations have been made without proper sealing and that the sealing in existing penetrations remains intact. The results of the monthly inspections will be reviewed in the quarterly QA Committee meetings. If there are no issues of non-compliance found during the monthly inspections, the QA Committee</p>		11/27/2012

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	<p>uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect the 12 residents in hall 5, residents in the main dining room, and seventeen residents in hall 2.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Environmental Services on 08/30/12 from 3:20 p.m. to 3:40 p.m., there was an unsealed penetrations above the lay in ceiling at the following fire barrier walls:</p> <p>a. around the damper and a water line at the hall 5 fire wall measuring one half inch each</p> <p>b. around wires sealed with expandable foam at the fire wall entering the main dining room.</p> <p>c. four penetrations around</p>		<p>may allow the inspections to continue on an annual basis. Otherwise, inspections will continue on a monthly basis and be reviewed again at the next QA Committee meeting. Administration requests an extension up to 11/27/12 to allow sufficient time for proposals to be obtained and work completed. Staff in the affected areas will be informed of the unsealed penetrations so that they can be better prepared in the event of a fire before the work is completed.</p>		

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	<p>conduit lines at the fire wall entering hall 2 measuring from one inch to four inches. These walls were confirmed to be a fire walls by the Director of Environmental Services.</p> <p>3.1-19(b)</p>			

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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/30/12</p> <p>Facility Number: 000501 Provider Number: 155635 AIM Number: 100266260</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist Robert Sutton, Trainee</p> <p>At this Life Safety Code survey, Grace Village Health Care Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. The Rehabilitation hall and Therapy were surveyed with Chapter 18 New Health Care Occupancies.</p> <p>This one story facility was</p>	K0000					

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	<p>determined to be of Type III (211) construction and was fully sprinklered. The Rehabilitation addition to the facility completed in 2007 was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridors. Battery operated smoke detectors were installed in all resident rooms in the original building. The new Rehabilitation Unit had hard wired smoke detectors. The facility has a capacity of 89 and had a census of 73 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage and in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered were the hall 5 elevator room, a fire pump room, a detached garage used for storage of maintenance</p>			

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	<p>equipment and parts with the portion of the building used as a maintenance garage, and a detached shed used for storage of parts and lawn equipment.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0048 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1</p> <p>Based on record review and interview, the facility failed to provide a written plan that included the different types and the use of fire extinguishers provided in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a review with the Director of Environmental Services on 08/30/12 at 12:50 p.m., the</p>	K0048	<p>No residents have been identified to have been affected by the cited deficiency. All staff are in-serviced on an annual basis on the types and uses of fire extinguishers in the building. In the few situations over the years that have warranted use of fire extinguishers, the staff responded each time appropriately and correctly according to their training. Wording will be added to the Emergency Manual to specifically describe the two types of fire extinguishers that are found in the facility and for what types of fires they are to be used. All staff will be informed of the modification to the Emergency Manual. The Director of Staff Development, or her designee, will review records to ensure that all staff have been in-serviced on the update to the Emergency Manual. The QA Committee will review the results of the monitoring at the quarterly QA Meeting and will re-evaluate the policy to ensure that the information regarding extinguishment of fires is up to date and accurate. If there are no concerns with non-compliance, the Committee will allow for monitoring to be conducted on an annual basis, otherwise it will continue on a quarterly basis.</p>	09/28/2012	

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	<p>"Emergency Manual" did not address the types of fire extinguishers throughout the facility including the kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. This was confirmed by the Director of Environmental Services at the time of record review.</p> <p>3.1-19(b)</p>			

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K0050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 4 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Grace village Fire Drill Procedure Form" with the Director of Environmental Services on 08/30/12 at 12:10 p.m., actual fire drills were not conducted for the second shift of the first quarter 2012, second and third shifts for the second quarter of 2012, or the second and third shifts for the third and fourth quarters of 2011. Based on an interview with the Director of Environmental Services at the time</p>	K0050	<p>No residents have been affected by the deficiency cited. Administration wishes to note that fire drills were, in fact, conducted and were done so on a more frequent basis than required. They simply were not conducted according to the State's interpretation of the code. The facility drills in question were initiated by the drill leader announcing a fire in a certain location (in person rather than on the overhead page) and having staff in that area explain and/or demonstrate exactly what they need to do to respond. The fire drill procedure will be updated to require that they are initiated by an overhead page, utilizing a coded alert, and that staff physically respond in the same manner they would as with an actual alarm. A log will be kept of each of these drills to document the steps that were taken. The staff responsible for leading the drills will be instructed on the revised procedure. The Director</p>	09/28/2012	

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	<p>of record review, he did not conducted an actual fire drill but instead did a walk thru question and answer session during the shifts listed above.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>of Environmental Services will monitor the logs to ensure that the drills have been conducted according to the revised procedure and according to the quarterly per shift frequency required. He will report the results of his monitoring to the QA Committee at its quarterly meetings for the next two quarters. The QA Committee will require continued quarterly monitoring if any instance of non-compliance is found.</p>		