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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E244 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 01/20/2012 |
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| NAME OF PROVIDER OR SUPPLIER RURAL HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218 |
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| K0000 | <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/20/12</p> <p>Facility Number: 000388 Provider Number: 15E244 AIM Number: 100454140</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Rural Health Care was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with automatic smoke detectors in the corridors and areas not separated from the corridor and single station smoke detectors in the resident sleeping rooms.</p> | K0000 | <p>This plan of correction is to serve as Rural Health Care's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Rural Health Care or its management company that the allegations contained in the survey report are true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p> | |
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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>The facility has a capacity of 50 and had a census of 40 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/26/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> | | | | |

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| K0029 SS=E | <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 2 hazardous areas, such as a soiled linen room, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect any resident who use the main corridor outside the main shower room.</p> <p>Findings include:</p> <p>Based on observation on 01/20/12 during the tour from 1:45 p.m. to 3:45 p.m. with the Maintenance Supervisor, the main shower room contained a double bin hamper with each bin having a 20 gallon capacity for soiled clothing and a 32 gallon trash container and the door lacked a self closing device. The Maintenance Supervisor at the time of observation, acknowledged the shower room door lacked a self closer, the soiled linen</p> | K0029 | <p>K029It is the practice of Rural Health Care to ensure residents are kept away from hazardous areas. The maintenance supervisor installed an automatic door closer on the shower room door. The soiled linen container has since been removed. II. Residents that use the north corridor have the potential to be effected. III. Housekeeping, laundry and nursing staff were were educated to ensure the soiled linen container is kept out of the shower room.IV. The maintenance supervisor or his designee will perform random checks to ensure the shower room door closes automatically. The maintenance supervisor or his designee will also perform random checks to ensure the soiled linin container is not put back into the shower room.</p> | 02/15/2012 | | | |

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| | <p>container was kept in the shower room until taken to laundry and the trash container was kept in the shower room until emptied.</p> <p>3.1-19(b)</p> | | | | | | |

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| K0038 SS=E | <p>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 1 of 3 exits were readily accessible for residents and staff. 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 patients require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice affects any resident using the smoking area exit.</p> <p>Findings include:</p> <p>Based on observation on 01/20/12 during the tour at 2:30 p.m. with the Maintenance Supervisor, the gate near the smoking area exit was locked with a pad lock that required a combination to open. Based on interview during the the time of observation, the Maintenance Supervisor indicated all the staff know the code to open the padlock. Based on interview of a staff person (CNA # 1) at 2:35 p.m., the</p> | K0038 | <p>K038 It is the pratice of Rural Health Care to ensure that exits are redily accessible at all times.I. Cna #1 was re-educated on how to open the pad lock on the gate.II. All resident's have the potential to be affected.III. The facility held an all staff inservice to educate all staff members on how to open the pad lock. IV. The Maintenance Supervisor or his designee will educate all new employees on how open the pad lock during the new hire orientation.</p> | 02/15/2012 | | | |

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| | <p>staff person did not know the code to open the pad lock on the gate. Further, interview with the Administrator during the exit conference at 4:00 p.m. on 01/20/12, indicated the staff person had been working in the facility for about one month.</p> <p>3.1-19(b)</p> | | | |
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| K0046 SS=F | <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review and interview, the facility failed to ensure 15 of 15 battery operated exterior emergency lights were tested annually in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants in the facility including staff, visitors and residents if the facility were required to evacuate in an emergency during a loss of normal power.</p> <p>Findings include:</p> <p>Based on review of the "Monthly Exit and Emergency Light Check" with the Maintenance Supervisor on 01/20/12 from 12:00 p.m. to 1:45 p.m., there was no written record of an annual test regarding the battery operated exterior emergency lights available for review. The Maintenance Supervisor during the</p> | K0046 | <p>K046It is the practice of Rural Health Care to test the emergency lighting in accordance with LSC 7.9. and LSC 19.2.9.1.1. The Maintenance supervisor was re-educated at the time regading the LSC standards not met.II. All residents have the potential to be affected.III. The monthly exit and emergency light check will be conducted the beginning of every month and logged on a from designed by the facility. The annual 90 minute test will be conducted every February and logged on the same form.IV. The administrator will conduct random checks of the forms to ensure the tests are being conducted.</p> | 02/15/2012 | | | |

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| | time of record review, acknowledged the documentation did not include an annual 90 minute test. 3.1-19(b) | | | | |

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| K0048 SS=F | <p>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 ensure its written fire safety plan incorporated all the items outlined in LSC 19.7.2.2. in order to protect 40 of 40 residents. LSC 19.7.1.1 requires every nursing home to have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire and for their evacuation to areas of refuge and for evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available.</p> <p>The provisions of LSC 19.7.1.2 to 19.7.2.3 inclusive shall apply. LSC 19.7.2.1 requires for health care occupancies, the proper protection of residents shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants, confinement of the effects of the fire by closing doors to isolate the fire area, and the execution of those evacuation duties as detailed in the</p> | K0048 | <p>It is the practice of Rural Health Care to have a written plan for the protection of all patients and for the evacuation in the event of an emergency.I. The Section D Fire Prevention Has been updated to reflect the installation of a sprinkler system. Section D has also been updated to reflect that the facility does not have dampers.II. All residents have the potential to be affected.III. The Maintenance Supervisor inserviced the facility's staff on when to use and the location of the Class K fire extinguisher. A plaque was also installed over the fire extinguisher to indicate that it is rated Class K.IV. All new employees will be inserviced by the Maintenance Supervisor or his designee on the when to use and the location of the Class K extinguisher.</p> | 02/15/2012 | | | |

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| | <p>facility's fire safety plan.</p> <p>LSC 19.7.2.2 states a written facility fire safety plan shall provide for:</p> <ul style="list-style-type: none"> (a) Use of alarms, (b) Transmission of alarm to fire department, (c) Response to alarms, (d) Isolation of fire, (e) Evacuation of immediate area, (f) Evacuation of smoke compartment (g) Preparation of building for evacuation (h) Extinguishment of fire. <p>This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Based on review of the facility's written policy titled "Section D Fire Prevention" provided by the Maintenance Supervisor on 01/20/12 from 12:00 p.m. to 1:45 p.m., the plan did not completely address extinguishment of fire. Specifically, the policy did not address the use of the K Class portable fire extinguisher located in the kitchen. The Maintenance Supervisor during the time of review, acknowledged the written policy did not address the use of the K Class portable fire extinguisher. 2. Based on review of the facility's written policy titled "Section D Fire Prevention" provided by the Maintenance Supervisor on 01/20/12 from 12:00 p.m. to 1:45 p.m., the plan was not complete or | | | | | | |

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| | <p>accurate. Specifically, the document was not updated to address the sprinkler system installed in 2011. The document indicated, "The facility does not have a sprinkler system." Additionally, the document indicated, "Automatic dampers are located throughout the facility for additional fire safety." The Maintenance Supervisor during the time of record review, acknowledged the facility does not have any dampers and the Fire Prevention policy was not accurate.</p> <p>3.1-19(b)</p> | | | |
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| K0050 SS=F | <p>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 interview and record review, the facility failed to conduct quarterly fire drills on each shift for 1 of 4 quarters. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Rural Healthcare Fire Drill" reports" with the Maintenance Supervisor from 12:00 p.m. to 1:45 p.m. on 01/20/12, a fire drill was not documented for the third shift of the third quarter of 2011. The Maintenance Supervisor during the time of review, acknowledged there was no other documentation available for review to verify this drill was conducted.</p> <p>3.1-19(b) 3.1-51(c)</p> | K0050 | <p>K 0050It is the practice of Rural Health Care to conduct fire drills according to LSC 19.7.1.2.I. The Maintenance was re-educated on the importance of documenting the facility's fire drills.II. All residents have the potential to to be affectedIII. A calendar is being incorporated to ensure that fire drills are being conducted at varying dates and times to be in compliance with K 0050. Random audits of drill will be conducted by the administrator to ensure that drills are in accordance.IV. The Administrator will perform random audits to ensure that fire drills are being performed at random times quarterly.</p> | 02/15/2012 | |

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| K0064 SS=B | <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect mostly staff while working in the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 01/20/12 from 1:45 p.m. to 3:45 p.m. with the Maintenance Supervisor during a tour of</p> | K0064 | <p>It is the practice of Rural Health Care to provide portable fire extinguishers in accordance with LSC 9.7.4.1.I. The Maintenance Supervisor obtained and installed a placard indicating the presence of the Class K extinguisher.II. Kitchen staff have the potential to be affected.III. Facility staff was inserviced regarding the location and how to use the class the extinguisher. IV. The Maintenance Supervisor or his designee will check randomly to ensure the placard remains in place.</p> | 02/15/2012 | |

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| | <p>the facility, there was a Class K portable fire extinguisher in the kitchen which lacked a placard. Based on interview at the time of observation, the Director of Maintenance acknowledged the Class K portable fire extinguisher lacked a placard.</p> <p>3.1-19(b)</p> | | | | |

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| K0075 SS=E | <p>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</p> <p>Based on observation and interview, the facility failed to store trash containers that exceeded 32 gallons in a hazardous area in accordance with LSC Section 19.7.5.5. This deficient practice could affect 20 of the 40 residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 01/20/12 during the tour from 1:45 p.m. to 3:45 p.m. with the Maintenance Supervisor, there was a 44 gallon trash can in the corridor near room 25 and a large paper shredder which was completely full in the corridor next to the nurses' station. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the presence of the 44 gallon trash container and indicated the gallon capacity of the paper shredder was unknown but probably exceeded 32 gallons.</p> <p>3.1-19(b)</p> | K0075 | <p>K 0075It is the practice of Rural Health Care to ensure trash and linen receptacles meet requirements set by LSC 19.7.5.5.I. The Maintenance Supervisor removed the 44 gallon trash container. II. 20 of 40 residents have the potential to be affected.III. The trash collection receptacles have been replaced with containers that do not exceed 32 gallons. The shred box have moved to a room containing a door closer.IV. The Maintenance Supervisor will ensure that future trash and linen receptacles meet LSC 19.7.5.5.</p> | 02/15/2012 | | | |

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| K0144 SS=F | <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on record review and interview, the facility failed to exercise the generator to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. for 5 of 5 months. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>This deficient practice could affect all residents, staff and visitors.</p> | K0144 | <p>K 0144It is the practice of Rural Health Care to ensure the proper documentation ensuring the off site fuel source for the emergency generator.I. The statement of reasonable reliability of the natural gas delivery was obtained Citizens Gas Co. immediately and is on file upon request.II. All residents have the potential to be affected.III. A form has been developed to ensure the monthly generator load testing is accurately documented. IV. The administrator or his designee will perform random checks to ensure that the monthly generator checks are documented accurately.</p> | 02/15/2012 | | | |

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| | <p>Findings include:</p> <p>Based on interview, with the Maintenance Supervisor at 1:00 p.m. on 01/20/12, the generator was installed on 9/20/11. Based on review of the "Generator Log" documentation at the time of interview, monthly load testing was documented with measurements but did not provide sufficient information to meet the requirements of NFPA 110, Chapter 6-4.2. This was acknowledged by the Maintenance Supervisor during the time of record review.</p> <p>3.1-19(b)</p> <p>2. Based on interview and record review, the facility failed to ensure the off site fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <ul style="list-style-type: none"> a) Liquid petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas <p>Exception: For Level 1 installations in</p> | | | | | | |

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| | <p>locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source.</p> <p>CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:</p> <ol style="list-style-type: none"> 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical person from the natural gas provider. <p>This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> | | | | | | |

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| | <p>Based on record review with the Maintenance Supervisor at 1:00 p.m. on 01/20/12, the facility did not have a letter of reliability from their natural gas provider. This was acknowledged by the Maintenance Supervisor during the time of record review, and it was also indicated the fuel source for the emergency generator was natural gas .</p> <p>3.1-19(b)</p> | | | |
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| K0154 SS=C | <p>Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 40 of 40 residents in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Watch Policy and Procedure with the Maintenance Supervisor on 01/20/12 during paperwork review from 12:00 p.m. to 1:45 p.m., the fire watch procedure for an out of service automatic sprinkler system was not complete. The procedure stated, "It is the policy of this provider to implement a fire watch in case of emergency situations in which the fire suppression and/or the fire alarm system are out of service for a period of time longer than 4 hours." Based on interview at the time of record review, the Maintenance Supervisor acknowledged</p> | K0154 | <p>K 0154It is the practice of Rural Health Care to enact an approved fire watch system in the event the sprinkler system is out of service for more than 4 hours in a 24 hour period.I. The facility's Fire Watch Policy was updated to reflect that if the sprinkler system is out of service for more than 4 hours in a 24 hour peroid, the authority having jurisdiction will be notified, and the building is evacuated or an approved fire watch system will be provided for all parties left unprotected by the shutdown until the sprinkler system is returned to service.II. All residents have the potential to be affected.</p> | 02/15/2012 | |

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| | the fire watch policy and procedure omitted the requirement for initiating a fire watch when the sprinkler system was out of service for 4 hours in a 24 hour period. 3.1-19(b) | | | | |

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| K0155 SS=C | <p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 40 of 40 residents in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Watch Policy and Procedure with the Maintenance Supervisor on 01/20/12 during paperwork review from 12:00 p.m. to 1:45 p.m., the fire watch procedure for an out of service fire alarm system was not complete. The procedure stated, "It is the policy of this provider to implement a fire watch in case of emergency situations in which the fire suppression and/or the fire alarm system are out of service for a period of time longer than 4 hours." Based on interview at the time of review, the Maintenance Supervisor acknowledged the fire watch policy and procedure omitted the requirement for</p> | K0155 | <p>K 0155It is the practice of Rural Health Care to ensure that the fire watch policy is instituted in accordance with LSC 9.6.1.8.I. The facility's Fire Watch Policy was updated to reflect that if the facility's sprinkler system is out of service for more than 4 hours in a 24 hour peroid, the authority having jurisdiction will be notified, and the building is evacuated or an approved fire watch system will be provided for all parties left unprotected by the shutdown until the sprinkler system is returned to service.II. All residents have the potential to be affected.</p> | 02/15/2012 | | | |

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| | <p>initiating a fire watch when the sprinkler system was out of service for 4 hours in a 24 hour period.</p> <p>3.1-19(b)</p> | | | | |