

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/13/2014
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NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268
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K010000	<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: 01/13/14</p> <p>Facility Number: 01156 Provider Number: 155505 AIM Number: 100453350</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Robin Run Health Center 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 V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke</p>	K010000	<p>I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission of agreement with the findings and conclusions in the Statement of Deficiencies. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allefgation or finding, nor have we identified mitigating factors. This provider respectfully requests that this 2567 Plan of Correction be considered the letter of Credible Allegation of Compliance and requests a Post Survey Review on or after February 12, 2014.</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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K010048 SS=B	<p>detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 84 and had a census of 71 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached maintenance building which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/21/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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 Based on record review, observation and interview; the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire</p>	K010048	K048 NFPA 101 Life Safety Code StandardIt is the practice of the provider to have a written plan for the protection of all patients and for their evacuation in the event of an emergency.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?The "Fire and Disaster Plan" has been revised to address the use of fire extinguishers located in the	02/12/2014

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	<p>department</p> <p>(3) Response to alarms</p> <p>(4) Isolation of fire</p> <p>(5) Evacuation of immediate area</p> <p>(6) Evacuation of smoke compartment</p> <p>(7) Preparation of floors and building for evacuation</p> <p>(8) Extinguishment of fire</p> <p>This deficient practice could affect five kitchen staff.</p> <p>Findings include:</p> <p>Based on review of "Fire & Disaster Plan" documentation with the Maintenance Director during record review from 9:10 a.m. to 12:00 p.m. on 01/13/14, the fire disaster plan did not address the use of fire extinguishers located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:50 p.m. on 01/13/14, one K-class fire extinguisher and two ABC type fire extinguishers were located in the kitchen. Based on interview at the time of record review, the Maintenance Director acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system</p>		<p>kitchen in relationship with the use of the kitchen overhead extinguishing system, and the Dietary staff have been educated on the revised policy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?The "Fire and disaster Plan" has been revised to address the use of fire extinguishers located in the kitchen in relationship with the use of the kitchen overhead extinguishing system, and the Dietary staff have been educated on the revised policy. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?The "Fire and Disaster Plan" has been revised to address the use of fire extinguishers located in the kitchen in relationship with the use of the kitchen overhead extinguishing system, and the Dietary staff have been educated on the revised policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The "Fire and Disaster Plan" has been revised to address the use of fire extinguishers located in the kitchen in relationship with the use of the kitchen overhead extinguishing system, and the Dietary staff have been educated</p>				

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K010050 SS=F	<p>to suppress a fire before using a portable fire extinguisher.</p> <p>3.1-19(a)</p> <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 Based on record review and interview, the facility failed to document activation of the fire alarm system for fire drills conducted between 6:00 a.m. and 9:00 p.m. on the first and second shift for 4 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility.</p>	K010050	<p>on the revised policy</p> <p>K050 NFPA 101 Life Safety Code StandardIt is the practice of the provider to document activation of the fire alarm system for fire drills conducted between 6:00am and 9:00pm.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Engineering staff have been educated on this standard and the supporting documentation. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?The Engineering staff have been educated on this standard and the supporting documentation. What measures</p>	02/12/2014	

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	<p>Findings include:</p> <p>Based on review of "Robin Run Health Care Center Fire Report" documentation with the Maintenance Director during record review from 9:10 a.m. to 12:00 p.m. on 01/13/14, documentation for first shift fire drills conducted on 02/26/13 at 6:30 a.m., on 07/02/13 at 6:30 a.m., on 12/11/13 at 6:30 a.m. and second shift fire drills conducted on 04/18/13 at 6:30 p.m. and on 05/14/13 at 8:30 p.m., each conducted after 6:00 a.m. but before 9:00 p.m., did not include transmission of the fire alarm signal. Each of the aforementioned first and second shift fire drill reports stated "No" in response to "Activation of alarm system." Based on interview at the time of record review, the Maintenance Director acknowledged documentation for the aforementioned first and second shift fire drills conducted after 6:00 a.m. and before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal.</p> <p>3.1-19(b)</p>		<p>will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?The Engineering staff have been educated on this standard and the supporting documentation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The fire drill process and documentation will be reviewed by the Quality Assurance Performance Improvement Committee monthly times 3 months, or until the deficient practice does not recur.</p>		

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K010062 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire & Security "Report of Inspection/Test" documentation dated 01/12/12 and "Sprinkler Inspection Report" documentation dated 08/16/13 with the Maintenance Director during record review from 9:10 a.m. to 12:00 p.m. on 01/13/14, facility sprinkler system gauges had not been recalibrated or replaced within the most recent five year period. The</p> <p>"Deficiency/Recommendations</p>	K010062	<p>K062 NFPA 101 LIFE SAFETY CODE STANDARDIt is the practice of the provider to maintain the automatic sprinkler system in reliable operating condition, and to inspect and test periodically.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?The 2006 and 2008 gauges have been replaced. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?The 2006 and 2008 gauges have been replaced. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?The 2006 and 2008 gauges have been replaced, and the internal preventative maintenance schedule has been updated to include recalibration or replacement within the five year period for all gauges. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The internal preventative maintenance</p>	02/12/2014			

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K010064 SS=B	<p>Summary" section of the 01/12/12 report stated "Gauges Out Of Date. Need Replaced." Item 7.F. of the 08/16/13 inspection report stated "No Year" in response to the "Test date" of sprinkler system gauges. Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:50 p.m. on 01/13/14, two of eight sprinkler gauges on the sprinkler system riser had a manufacture date of 2006 and the remaining six of eight sprinkler gauges on the sprinkler system riser had a manufacture date of 2008. Based on interview at the time of the observations, the Maintenance Director acknowledged each of the aforementioned sprinkler system gauges had exceeded the five year requirement for recalibration or replacement.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the</p>	K010064	<p>schedule has been updated to include recalibration or replacement within the five year period for all gauges.</p> <p>K064 NFPA 101 LIFE SAFETY</p>	02/12/2014			

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	<p>facility failed to inspect 2 of 14 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect 7 kitchen and laundry staff.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:50 p.m. on 01/13/14, the annual maintenance tag attached to the portable fire extinguisher located in the kitchen near the exit door to the smoking area and the annual maintenance tag attached to the portable fire extinguisher located in the laundry indicated monthly inspections were not</p>		<p>CODE STANDARDIt is the practice of the provider to inspect portable fire extinguishers in accordance with the regulatory standard.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?The fire extinguisher inspection tool has been revised to include the Main Kitchen and Main Laundry areas, and the Courtesy Office staff have been educated on this revision. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?The fire extinguisher inspection tool has been revised to include the Main Kitchen and Main Laundry areas, and the Courtesy Office staff have been educated on this revision. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?The fire extinguisher inspection tool has been revised to include the Main Kitchen and Main Laundry areas, and the Courtesy Office staff have been educated on this revision. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The completed fire extinguisher inspection tool will be reviewed by the Quality Assurance Performance</p>	

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	<p>documented for August 2013 through December 2013. Based on interview at the time of observation, the Maintenance Director stated no other monthly fire extinguisher inspection documentation was available for review and acknowledged a monthly inspection for the aforementioned portable fire extinguishers was not documented for August 2013 through December 2013.</p> <p>3.1-19(b)</p>		<p>Improvement Committee monthly times 3 months, or until the deficient practice does not recur.</p>		

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K010066 SS=A	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container with a self closing lid at 2 of 2 outside areas where smoking was permitted. This deficient practice could affect five staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:50 p.m. on 01/13/14, the staff smoking area</p>	K010066	K066 NFTA 101 Life Safety Code StandardIt is the practice of the provider to comply with smoking regulations.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?The provider will purchase receptacles for personal smoking materials that meet with the regulatory standards and place them in authorized smoking areas for associate use. How other residents having the potential to be affected by the same deficient practice will be identified and	02/12/2014			

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K010144 SS=F	<p>located outside of the building at the kitchen exit and the staff smoking area thirty feet outside of the building at the kitchen exit near the parking lot each had in excess of 100 extinguished cigarette butts deposited on the ground. A noncombustible ash tray and a metal container with a self closing cover device into which ashtrays can be emptied were not provided in each of these two areas where staff smoking was taking place. Based on interview at the time of observation, the Maintenance Director acknowledged cigarette butts were disposed of on the ground by staff and a noncombustible ash tray and metal container with a self closing cover device into which ashtrays can be emptied were not provided at the aforementioned outside smoking areas.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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, observation,</p>	K010144	<p>what corrective actions(s) will be taken?The provider will purchase receptacles for personal smoking materials that meet with the regulatory standards and place them in authorized smoking areas for associate use. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?The provider will purchase receptacles for personal smoking materials that meet with the regulatory standards and place them in authorized smoking areas for associate use. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The provider will purchase receptacles for personal smoking materials that meet with the regulatory standards and place them in authorized smoking areas for associate use.</p> <p>K144 NFPA 101 LIFE SAFETY</p>	02/12/2014			

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	<p>and interview; the facility failed to ensure a monthly load test for the emergency generator was conducted for 12 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators 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. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p>		<p>CODE STANDARDIt is the practice of the provider to inspect the generators weekly and exercise under load for 30 minutes per month.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?The Engineering Director will be educated on the proper process for, and documentation of, the generator load testing by a consultant company representative. The Emergency Generator Monthly Test Log will be revised to include confirmation of the timely transfer of emergency power. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?The Engineering Director will be educated on the proper process for, and documentation of, the generator load testing by a consultant company representative. The Emergency Generator Monthly Test Log will be revised to include confirmation of the timely transfer of emergency power. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?The Engineering Director will be educated on the proper process for, and documentation of, the generator load testing by a consultant company</p>				

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	Based on review of "Emergency Generator - Monthly Test Log" documentation with the Maintenance Director during record review from 9:10 a.m. to 12:00 p.m. on 01/13/14, monthly load test documentation for the period of 01/29/13 through 09/26/13 and November 2013 stated a load kW rating higher than the nameplate kW rating of the generator. The load kW rating documentation stated 220 kW for each of the ten documented monthly load tests. Monthly load test documentation for October 2013 and December 2013 was not available for review. The aforementioned documentation did not indicate if the emergency generator ran under operating temperature conditions, at not less than 30% of the EPS nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:50 p.m. on 01/13/14, the nameplate rating of the emergency generator was listed as 125 kW. Based on interview at the time of record review and observation, the Maintenance Director stated no additional monthly load testing documentation was available for review, the nameplate rating of the emergency generator is 125kW and acknowledged		representative. The Emergency Generator Monthly Test Log will be revised to include confirmation of the timely transfer of emergency power. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The completed Emergency Generator Monthly Test Log will be reviewed by the Quality Assurance Performance Improvement Committee monthly times 3 months, or until the deficient practice does not recur.	

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	<p>monthly load test documentation did not indicate if the emergency generator ran under operating temperature conditions, at not less than 30% of the EPS nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 12 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency</p>				

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	Generator - Monthly Test Log" documentation with the Maintenance Director during record review from 9:10 a.m. to 12:00 p.m. on 01/13/14, load testing documentation for emergency power transfer time for the twelve month period of January 2013 through December 2013 was not available for review. Based on interview at the time of record review, the Maintenance Director stated no additional generator transfer time documentation for emergency power transfer time was available for review and acknowledged emergency power transfer time was not documented for the twelve month period of January 2013 through December 2013. 3.1-19(b)						
K010147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and	K010147	K147 NFPA 101 LIFE SAFETY CODE STANDARDIt is the practice of the provider to not use power strips as a substitute for fixed wiring.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	02/12/2014			

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	<p>cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 30 residents, staff and visitors in the Main Dining Room in the vicinity of the Admission Office.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:50 p.m. on 01/13/14, a refrigerator, coffee pot and a microwave oven were plugged into a power strip in the Admission Office and a refrigerator and a microwave oven were plugged into a power strip in the Unit Manager's Office.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged extension cords including power strips were in use as a substitute for fixed wiring at the aforementioned locations.</p> <p>3.1-19(b)</p>		<p>practice?The power strips in the Admission Office and the Unit Manager office have been audited, and are not being used as a substitute for fixed wiring. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?All other offices have been audited for appropriate use of a power strip when applicable. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?A new power strip protocol has been developed to outline the regulatory guidelines for office use, and the leadership team members have been educated on the new protocol. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The Engineering Department will audit the use of power strips in offices quarterly times 2 quarters, or until the deficient practice does not recur.</p>				

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K010154 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period in order to protect 71 of 71 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Watch" documentation with the Maintenance</p>	K010154	<p>K154 NFPA 101 LIFE SAFETY CODE STANDARD It is the practice of the provider to notify all indicated parties in the event that the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Fire Watch protocol has been revised and the leadership team has been educated on this revision. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken? The Fire Watch protocol has been revised and the leadership team has been educated on this revision. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Fire Watch protocol has been revised and the leadership team has been educated on this revision. How</p>	02/12/2014			

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	<p>Director during record review from 9:10 a.m. to 12:00 p.m. on 01/13/14, the fire watch policy did not include notification of the insurance carrier and alarm notification company in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period. Based on interview at the time of record review, the Maintenance Director stated no additional fire watch documentation was available for review and acknowledged the written fire watch policy did not include notification of the insurance carrier and alarm monitoring company in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period.</p> <p>3.1-19(b)</p>		<p>the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The Fire Watch protocol has been revised and the leadership team has been educated on this revision.</p>		