STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 12/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY HEALTH CARE	627 E NORTH ST GAS CITY, IN 46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 12/16/14 Facility Number: 000137 Provider Number: 155232 AIM Number: 100266140 Surveyor: Amy Kelley, Life Safety Code Specialist; Thomas Forbes Life Safety Code Specialist. At this Life Safety Code survey, Twin City 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. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 75 and had	K010000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	a census of 55 at the time of this survey. Quality Review by Dennis Austill, Life Safety Code Specialist on 12/23/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010025 SS=E	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 Based on observation and interview, the facility failed to ensure the penetrations in 3 of 6 smoke barrier walls were 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	K010025	Addendum to: Defeciency ID: K _ 0025 Completion Date: 1/8/2015 **K025 Corrective action for residents affected**: No residents were affected by this alleged negative practice. All areas of penetration in smoke barrier walls have been re-sealed with Fire Barrier Sealant. (Attachment E) Areas around data wire on D hall, around sprinkler pipe on C hall, and around wire at A hall smoke barrier have been sealed with fire barrier sealant.	01/08/2015

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	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 the specific purpose. This deficient practice could affect 34 residents in 4 of 7 smoke compartments. Findings include: Based on an observation and interview with the Maintenance Supervisor and Administrator on 08/07/14 between 1:17 p.m. to 1:33 p.m. the following was observed: (a) There was a one and a half inch unsealed penetration around the data wire at the D hall smoke barrier wall above ceiling tile. (b) There was a half inch unsealed penetration around sprinkler pipe at the C hall smoke barrier in the attic. (c) There was a half inch unsealed penetration around a wire at the A hall smoke barrier in the attic. Measurements were provided by the Maintenance Supervisor at the time of observation. 3.1-19(b)		**Other residents having potential to be affected and corrective action**: No residents were affected by this alleged negative practice. All areas of penetration in smoke barrier walls have been re-sealed with fire Barrier Sealant. Areas around data wire on D hall, around sprinkler pipe on C hall, and around wire at A hall smoke barrier have been sealed with fire barrier sealant. **Measures to ensure that the practice does not recur**: Maintenance director was reeducated of regulation related to penetrations of smoke barriers. Any repairs or maintenance that affects the smoke barrier walls have been sealed with fire prevention caulk. **This corrective action will be monitored by:** Maintenance Supervisor and Administrator will monitor smoke barriers monthly to ensure they are free of penetration. Any areas found will be sealed. Monitoring will be ongoing. **Completed: 1/8/2015**	

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K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure ceiling penetrations of 6 of 6 in a hazardous area such a kitchen or boiler room was maintained to be smoke resistive. This deficient practice could affect 34 residents in 3 of 7 smoke compartments. Findings include: Based on observation and interview with the Maintenance Supervisor and Administrator on 12/16/14 between 11:55 a.m. and 12:59 p.m. the Maintenance Supervisor acknowledged the following: (a) in the sprinkler riser room there were four unsealed penetrations ranging in size from one fourth inch to three forth inch around wires and piping. (b) in the kitchen there was one unsealed	K010029	Addendum to: Defeciency ID: K _ 0029 Completion Date: 1/8/2015 Plan of Correction Text: **K029 Corrective action for residents affected**: No residents were affected by this alleged negative practice. Areas on ceiling in sprinkler room, kitchen and D hall Water Heater Room have been repaired with fire barrier sealant. Attachment E All areas of unsealed penetration have been sealed with Fire Barrier Sealant. **Other residents having potential to be affected and corrective action**: No residents were affected by this alleged negative practice. Areas on ceiling in sprinkler room, kitchen and D hall Water Heater Room have been repaired with fire barrier sealant. (Attachment E) All areas of unsealed penetration have been sealed.	01/08/2015

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	penetration about one half inch in size around an electrical conduit for the hood fire suppression system. (c) in the D hall Water Heater Room there was one unsealed crack in the ceiling above the water heater due to water damage about three eights in size and six inches long. Measurements were provided by the Maintenance Supervisor at the time of observations. 3.1-19(b)		**Measures to ensure that the practice does not recur**: Maintenance director was reeducated on requirement for smoke barriers to be free of penetrations. Inspection by Maintenance Supervisor at end of repair or routine maintenance to ensure no areas of penetration are left unsealed. **This corrective action will be monitored by:** Maintenance Supervisor and Administrator will monitor monthly to ensure smoke barriers have not been penetrated. Any areas found with penetration will be repaired. Monitoring will be ongoing. **Completed: 1/8/2015**	
K010046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency light fixtures of at least 30 seconds duration was tested monthly and 1½ hour duration tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be	K010046	**K046 Corrective action for residents affected**: No residents were affected by this alleged negative. Log has been established to document testing of battery operated light for the generator. (Attachment A)**Other residents having potential to be affected and corrective action**: No residents were affected by this alleged negative practice. Log has been established to document testing of battery operated light for the	01/08/2015

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	conducted on every required battery powered emergency lighting system for at least 1½ 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. Findings include: Based on an observation and records review with the Maintenance Supervisor on 12/16/14 at 11:05 a.m., a battery operated emergency light log was not available for the emergency light for the generator showing the light was tested monthly for a duration of 30 seconds and annually for a duration of 1½ hours. Based on an interview at the time of observation, the Maintenance Supervisor stated he was testing the emergency light but was not documenting his tests. Therefore, there was no written record of a monthly test or an annual test regarding the battery operated emergency light available for review. 3.1-19(b)		generator. (Attachment A) **Measures to ensure that the practice does not recur**: Maintenance Supervisor was reeducated and will test battery operated light located at the generator monthly for 30 seconds and annually for 1.5 hours. Log sheet will be filled out when test is done. **This corrective action will be monitored by:** Maintenance Supervisor and Administrator will monitor log during monthly quality assurance committee meeing, any concerns will be immediatley corrected. Monitoring will be ongoing. **Completed: 1/8/2015**	
K010048 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD			

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	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 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: (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 This deficient practice could affect all occupants. Findings include: Based on a record review with the Maintenance Supervisor on 12/16/14 at 10:58 p.m., the "Disaster Manual " did not address the types of fire extinguishers throughout the facility including the ABC fire extinguisher in relationship with the types of fires that it can put out. This was confirmed by the Maintenance	K010048	**K048 Corrective action for residents affected**: No residents were affected by this alleged negative. Documentation of Fire Extinguishers and the correct usage of the different types of extinguishers has been added to the disaster manual. (Attachment B)**Other residents having potential to be affected and corrective action**: No residents were affected by this alleged negative practice. Documentation of Fire Extinguishers and the correct usage of the different types of extinguishers has been added to the disaster manual. (Attachment B) **Measures to ensure that the practice does not recur**: Maintenance director was reeducated on regulation of fire extingushers. Disaster Manuals will be monitored monlty to ensure information is updated and correct. **This corrective action will be monitored by:** Administrator will review disaster manual during monthly quality assurance meeting to ensure information is updated and complete. Monitoring is ongoing.**Completed by: 1/8/15**	01/08/2015

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	Supervisor at the time of record review. 3.1-19(b)			
K010056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler heads in the D hall water heater room were separated by at least six feet as required by NFPA 13. NFPA 13 Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect 20 resident in the D hall in the event of a fire emergency.	K010056	**K056 Corrective action for residents affected**: No residents were affected by this alleged negative. One sprinkler head in Water Heater room has been capped off, eliminating 2 sprinkler heads being closer that the required 6 feet. **Other residents having potential to be affected and corrective action**: No residents were affected by this alleged negative practice. One sprinkler head in Water Heater room has been capped off,	01/08/2015

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	Findings include: Based on observations with the Administrator and Maintenance Supervisor, on 12/16/14 at 12:31 p.m. the D hall water heater room had two sprinkler heads located less than six feet apart. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		eliminating 2 sprinkler heads being closer that the required 6 feet. **Measures to ensure that the practice does not recur**: Maintenance director was reeducated to requirement of sprinkler heads. Sprinkler head it to remain capped off..**This corrective action will be monitored by:** Maintenance Supervisor will monitor sprinkler heads throughtout facility monthly to ensure facility remains within regulation requirements. And negative findings will be corrected immediatly. Monitoring will be reviewed in monthly quality assurance committee for continued compliance. Monitoring is ongoing. **Completed: 1/8/2015**	
K010064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to maintain 1 of 1 K Class 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 use 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	K010064	**K064 Corrective action for residents affected**: No residents were affected by this alleged negative. K Class fire extinguisher has been replaced in kitchen area. **Other residents having potential to be affected and corrective action**: No residents were affected by this alleged negative practice. K Class fire extinguisher has been replaced in kitchen area. **Measures to ensure that the practice does not recur**: Maintenace director will be	01/08/2015

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	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 any residents using the main dining room and all kitchen staff. Findings include: Based on observation with the Maintenance Supervisor and Administrator on 12/16/14 at 1:03 p.m., there was no K Class fire extinguisher in the kitchen. Also, there was an ABC fire extinguisher under the placard for the K class. Based on an interview with the Maintenance Director at the time of observation, he stated that the kitchen K Class fire extinguisher was out for service and an ABC extinguisher was in its place. 3.1-19(b)		reeducated on fire entingusher requirement. Monthly checks will be done per Maintenance Supervisor to ensure K Class fire extingusher remains in the kitchen.**This corrective action will be monitored by:** Maintenance Supervisor will monitor fire extingushers monthly to ensure all extinguishers are in appropropriate locations. Monitoring will be reviewed in monthly quality assurance committee to ensure continued compliance. Andy negative findings will be corrected immediately. Monitoring will be ongoing. **Completed: 1/8/2015**	

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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 1 of 1 wet location in the Respiratory Therapy restroom was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas that are subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 1 resident in the Therapy office. Findings include: Based on observation with the Maintenance Supervisor and Administrator on 12/16/14 at 12:50 p.m., there was an electric receptacle was on	K010147	**K147Corrective action for residents affected**: No residents were affected by this alleged negative. Receptacle has been replaced with GFCI protection in bathroom of respiratory therapy office. **Other residents having potential to be affected and corrective action**: No residents were affected by this alleged negative practice. Receptacle has been replaced with GFCI protection in bathroom of respiratory therapy office. **Measures to ensure that the practice does not recur**: Monthly monitoring of receptacles that are within wet areas will be monitored by maintenance staff for correct GFCI protection.**This corrective action will be monitored by:** Maintenance Supervisor monthly monitoring will be reviewed in monthly quality assurance committee meeting. Any negative findings will be corrected immediately. Monitoring will be ongoing. **Completed: 1/8/2015**	01/08/2015

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	the wall within three feet of the restroom sink in the Respiratory Therapy restroom was not GFCI protected. Based on interview and testing with the Maintenance Supervisor at the time of observation, neither the electrical outlets nor the circuit breakers for these outlets were provided with GFCI protection. 3.1-19(b)			
K010154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to provide a complete written policy for the protection of residents indicating procedures to be followed in the event the sprikler system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. for the protection of 55 of 55 residents. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the	K010154	**K154 Corrective action for residents affected**: No residents were affected by this alleged negative. Fire watch policy and procedure added to disaster manual. Staff in serviced on fire watch policy and responsibilities of Impairment Coordinator. (Attachment D)**Other residents having potential to be affected and corrective action**: No residents were affected by this alleged negative practice. Fire watch policy and procedure added to disaster manual. Staff	01/08/2015

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	protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 Requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice affects all occupants. Findings include: Based on record review of the "Fire Watch Policy Procedure" with the Maintenance Supervisor on 12/16/14 at 10:50 a.m., the facility did have a written policy and procedure for an impaired fire alarm system available for review, but the Fire Watch Policy Procedure at the nurse station did not state the designated person(s) shall be trained on how to conduct the fire watch. Based on an interview with the Maintenance Supervisor at the time of record review, he acknowledged the fire watch policy documentation lacked a statement indicating the person(s) conducting the fire watch shall small be trained.		in serviced on fire watch policy and responsibilities of Impairment Coordinator. (Attachment D) **Measures to ensure that the practice does not recur**: Routine training and retraining of staff on fire watch policy as well as responsibilities of Impairment Coordinator. Information will be gone over after each fire drill. **This corrective action will be monitored by:** Monitoring and staff education of policy will be reviewed in monthly quality assurance committee meeting for continued compliance. Any negative findings will be corrected immediately. Monitoring will be ongoing. **Completed: 1/8/2015**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 12/16/2014
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD 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 Based on record review and interview, the facility failed to provide a complete written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. for the protection of 55 of 55 residents. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 Requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm	K010155	**K155 Corrective action for residents affected**: No residents were affected by this alleged negative practice. Fire Watch policy updated and added to disaster manuals. Staff in serviced on Fire watch and procedure if building fire alarm system has been placed out of service. (Attachment C)**Other residents having potential to be affected and corrective action**: No residents were affected by this alleged negative practice. Staff in serviced on Fire watch and procedure if building fire alarm system has been placed out of service. **Measures to ensure that the practice does not recur**: Routine training to staff and new employees on fire watch policy and procedures and what situations qualifies for fire watch according to policy. Reminder of fire watch policy and procedures at each fire drill monthly. **This corrective action will be monitored by:** Monitoring and staff education of policy will be reviewed in monthly quality	01/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 12/16/2014
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	during a malfunction of the building fire alarm system. This deficient practice affects all occupants. Findings include: Based on record review of the "Fire Watch Policy Procedure" with the Maintenance Supervisor on 12/16/14 at 10:50 a.m., the facility did have a written policy and procedure for an impaired fire alarm system available for review, but the Fire Watch Policy Procedure at the nurse station did not state the designated person(s) shall be trained on how to conduct the fire watch. Based on an interview with the Maintenance Supervisor at the time of record review, he acknowledged the fire watch policy documentation lacked a statement indicating the person(s) conducting the fire watch shall small be trained. 3.1-19(b)		assurance committee meeting for continued compliance. Any negative findings will be corrected immediatly. Monitoring will be onging. **Completed: 1/8/2015**	