

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2012
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NAME OF PROVIDER OR SUPPLIER PINE HAVEN HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3400 STOCKER DR EVANSVILLE, IN47720
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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: 01/09/12</p> <p>Facility Number: 000442 Provider Number: 155621 AIM Number: 100266510</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Pine Haven Health and Rehabilitation 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), and 410 IAC 16.2. The original two story section and Stocker Addition I were surveyed with Chapter 19, Existing Health Care Occupancies.</p>	K0000	This is in response to the Life Safety Code Recertification and State Licensure Survey conducted by the Indiana State Department of Health at this facility on January 9, 2012.	

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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K0029 SS=E	<p>This building consists of two sections; the original portion of the building was a two story, fully sprinklered building determined to be of Type I (332) construction, and the Stocker Addition I was a one story, fully sprinklered building determined to be of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident rooms in the Stocker Addition I. The facility has a capacity of 120 and had a census of 100 at the time of this survey.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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</p>	K0029	K 029	01/11/2012	

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	<p>interview, the facility failed to ensure 1 of 14 hazardous area room doors, such as a room over 50 square feet containing a large amount of combustibile material such as cardboard boxes, mop heads, and housekeeping chemicals was equipped with a self closing device on the door. This deficient practice could affect 23 residents, as well as staff and visitors in the upper level south unit.</p> <p>Findings include:</p> <p>Based on observation on 01/09/12 at 12:15 p.m. during a tour of the facility with Director of Maintenance, the upper level south storage closet was over fifty square feet in size and full of cardboard boxes, mop heads, and housekeeping chemicals. The door to this room was not provided with a self closing device. This was acknowledged by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p>		<p><i>The corrective action accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>A self closing device has been added to the door of the upper level south storage closet.</p> <p><i>How other residents having the potential to be affected will be identified and what corrective action will be taken:</i></p> <p>No other residents were found to be affected.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</i></p> <p>All hazardous area room doors will be equipped with a self closing device.</p> <p><i>How the corrective action will be monitored, i.e., what quality assurance program will be put into place:</i></p> <p>N/A</p>		

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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 provide a complete written fire safety plan for the protection of 100 of 100 residents in the event of an emergency addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan 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 in the event of an emergency.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire safety plan in the</p>	K0048	<p><i>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</i></p> <p>Upon orientation, all new employees will receive instruction on the use of ABC-type fire extinguishers. In addition, dietary employees will also receive instruction on the use of the K-class fire extinguishers. This instruction will be done by the Maintenance Director or his designee during the tour of the facility. Current employees will continue to receive fire safety training at least annually.</p>	02/08/2012			

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	<p>Emergency Preparedness Plan on 01/09/12 at 10:55 a.m. with the Director of Maintenance present, the fire safety plan did not address how to use the ABC type fire extinguishers located throughout the building, or mention the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on an interview at the time of record review, the Director of Maintenance acknowledged the written fire safety plan did not include how to use the ABC type fire extinguishers, or mention the kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using the K class fire extinguisher.</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>1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Maintenance Inservice Book on 01/09/12 at 10:00 a.m. with the Director of Maintenance present, the facility lacked written documentation a fire drill was conducted during the third (night) shift of the first quarter (January, February, and March) of 2011. This was acknowledged by the Director of Maintenance at the time of record review.</p>	K0050	<p>K 050</p> <p><i>The corrective action accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>1. The Maintenance Director responsible for fire drills during first quarter of 2011 is no longer employed here. The current Maintenance Director is aware of the required frequency of fire drills. Written documentation is maintained in the Maintenance office.</p> <p>2. Fire drills will be held at varied times on each shift. Documentation maintained in Maintenance office.</p> <p>3. Complete documentation of the transmission of the fire alarm signal to the monitoring company will be obtained for all fire drills. On January 19, 2012, Administrator and Maintenance Director met with Robert Horton of Priority One Fire & Security to discuss procedure for verifying transmission of drills. The Maintenance Director will request faxed verification of fire alarm signal transmission following each fire drill.</p>	02/08/2012

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	<p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 3 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Maintenance Inservice Book on 01/09/12 at 10:00 a.m. with the Director of Maintenance present, three of four first shift (day) fire drills since January of 2011 were performed between 1:30 p.m. and 2:40 p.m., three of four second shift (evening) fire drills since January of 2011 were performed between 3:55 p.m. and 4:05 p.m., and four of four third shift (night) fire drills since January of 2011 were performed between 6:15 a.m. and 6:45 a.m. During an interview at the time of record review, the Director of Maintenance acknowledged the times of the first, second, and third shift fire drills.</p>		<p>A report will be emailed to the Administrator the first of each month that verifies the transmission of previous month's fire alarm signals. These reports will be reconciled monthly.</p> <p><i>How other residents having the potential to be affected will be identified and what corrective action will be taken:</i></p> <p>N/A</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</i></p> <p>Maintenance Director will obtain documentation of transmission of the fire alarm signal to the monitoring company following all fire drills.</p> <p><i>How the corrective action will be monitored, i.e., what quality assurance program will be put into place:</i></p> <p>This documentation will be maintained in the Maintenance office.</p>		

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	<p>3-1.19(b)</p> <p>3. Based on record review and interview, the facility failed to ensure each documented fire drill included complete documentation of the transmission of a fire alarm signal to the monitoring company for 2 of 12 drills. LSC 19.7.1.2 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills since January of 2011 in the Maintenance Inservice Book on 01/09/12 at 10:00 a.m. with the Director of Maintenance present, two of the twelve documented fire drill reports dated 01/31/11 and 02/02/11 did not include information the monitoring company received the transmission of the alarm. During an interview at the time of record review, the Director of</p>				

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K0052 SS=F	<p>Maintenance indicated the monitoring company was always contacted before and after a fire drill was conducted during all shifts, but acknowledged the two fire drill reports did not include this information.</p> <p>3-1.19(b)</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure 8 of 102 smoke detectors were tested annually. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors be tested annually. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's quarterly fire alarm system inspection reports in the</p>	K0052	<p>K 052 <i>The corrective action accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>Maintenance Director and Administrator met with Robert Horton of Priority One Fire & Security on January 19, 2012 and determined all 102 smoke detectors were, in fact, tested annually. The missing reports were due to a clerical error on the part of the testing service. The documentation will be provided by the testing service.</p> <p><i>How other residents having the potential to be affected will be identified and what corrective action will be taken:</i></p> <p>N/A</p> <p><i>What measures will be put into</i></p>	02/08/2012	

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	<p>Maintenance Inservice Book on 01/09/12 at 1:50 p.m. with the Director of Maintenance present, the four most recent quarterly fire alarm system inspection reports dated 02/08/11, 05/05/11, 08/26/11, and 11/28/11 had a total of ninety four smoke detectors tested visually and functionally. The most recent smoke detector sensitivity test dated 11/22/10 indicated one hundred two smoke detectors were tested and passed. That left eight smoke detectors unaccounted for during the past four quarterly fire alarm system inspections. During an interview at the time of record review, the Director of Maintenance acknowledged the number of smoke detectors listed in the quarterly fire alarm system reports and the most recent sensitivity test report were not consistent.</p> <p>3-1.19(b)</p>		<p><i>place or what systemic changes will be made to ensure the deficient practice does not recur:</i> N/A</p> <p><i>How the corrective action will be monitored, i.e., what quality assurance program will be put into place:</i> Maintenance Director will maintain the quarterly fire alarm system inspection reports in the Maintenance office and reconcile the documented number of smoke detectors tested with the number of smoke detectors in the facility.</p>		

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K0056 SS=E	<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 provide sprinkler coverage for 1 of 4 areas outside and attached to the building and constructed of combustibile material. NFPA 13, 1999 Edition at 5-13.8.1 requires sprinklers be installed under combustibile exterior roofs exceeding four feet in width. This deficient practice could affect any of the 23 residents, plus staff and visitors in the upper level south unit.</p> <p>Findings include:</p> <p>Based on observation on 01/09/12 at 12:05 p.m. during a tour of the facility with the Director of Maintenance, the upper level south unit exit had a twelve</p>	K0056	<p>K 056</p> <p><i>The corrective action accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>The awning over the upper level south unit exit will be replaced with a canopy made of a fire rated material. Bids have been received and a work order has been issued.</p> <p><i>How other residents having the potential to be affected will be identified and what corrective action will be taken:</i></p> <p>N/A</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</i></p> <p>N/A</p> <p><i>How the corrective action will be monitored, i.e., what quality assurance program will be put into place:</i></p> <p>N/A</p>	02/08/2012	

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K0064 SS=B	<p>foot by thirty foot canvas canopy overhang attached to the building. There was no fire rating on the canvas canopy and there was no sprinkler coverage provided under the canopy. This was confirmed by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p> <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 2 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</p>	K0064	<p>K 064</p> <p><i>The corrective action accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>The required placard will be obtained and placed near the Class K fire extinguisher in the kitchen.</p> <p><i>How other residents having the potential to be affected will be identified and what corrective action will be taken:</i></p> <p>N/A</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</i></p> <p>Kitchen staff will be trained on the proper use of the Class K fire extinguisher used for combustible cooking media following the activation of the fixed fire protection system. This will be done by the Maintenance Director.</p>	02/08/2012	

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K0069 SS=E	<p>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 01/09/12 at 12:30 p.m. with the Director of Maintenance during a tour of 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> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>Based on record review, interview and observation; the facility failed</p>	K0069	<p><i>How the corrective action will be monitored, i.e., what quality assurance program will be put into place:</i></p> <p>N/A</p> <p>K069</p> <p><i>The corrective action accomplished for those residents found to have</i></p>	02/08/2012	

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	<p>to ensure 1 of 1 kitchen exhaust systems was cleaned at least semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1 requires systems serving moderate volume cooking operations shall be inspected semiannually. This deficient practice could affect mostly kitchen staff, plus any residents and visitors while in the lower level north section of the facility which included the Activity room.</p> <p>Findings include:</p>		<p><i>been affected by the deficient practice:</i> The kitchen exhaust system has been cleaned January 20, 2012, by PureOne and semiannual cleanings will continue to be scheduled. <i>How other residents having the potential to be affected will be identified and what corrective action will be taken:</i> N/A <i>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</i> Maintenance Director will schedule semiannual cleanings of the kitchen exhaust system. The semiannual cleaning of the kitchen exhaust system will be added to the preventive maintenance schedule and scheduled accordingly. <i>How the corrective action will be monitored, i.e., what quality assurance program will be put into place:</i> N/A</p>				

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K0147 SS=E	<p>Based on review of the kitchen range inspection reports in the Maintenance Inservice Book on 01/09/12 at 10:35 a.m. with the Director of Maintenance present, there was no documentation to show the kitchen range hood had been cleaned within the past six months. Based on observation at 12:32 p.m. during a tour of the facility with the Director of Maintenance, there was a sticker on the kitchen range hood which indicated the range hood was last cleaned on 04/22/11. This was confirmed by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 3 power strips observed were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999</p>	K0147	<p>K 147</p> <p><i>The corrective action accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>Room 219-A licensed electrician will add receptacles to this room to accommodate residents' needs.</p> <p>Room 220- A licensed electrician will add receptacles to this room to accommodate residents' needs.</p> <p><i>How other residents having the</i></p>	02/08/2012	

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K0000	<p>Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 3 residents in resident rooms 219, and 220.</p> <p>Findings include:</p> <p>Based on observations on 01/09/12 between 11:00 a.m. and 1:45 p.m. during a tour of the facility with the Director of Maintenance, resident room 219 had a microwave and small refrigerator plugged into a power strip, and resident room 220 had a small refrigerator plugged into a power strip. This was acknowledged by the Director of Maintenance at the time of each observation.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in</p>	K0000	<p><i>potential to be affected will be identified and what corrective action will be taken:</i></p> <p>Maintenance and Housekeeping departments have audited all rooms in the original building to ensure that no flexible cords and cables are being used as a substitute for fixed wiring. Where needed, furniture was repositioned and receptacles will be added if necessary.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</i></p> <p>N/A</p> <p><i>How the corrective action will be monitored, i.e., what quality assurance program will be put into place:</i></p> <p>N/A</p> <p>This is in response to the Life Safety Code Recertification and State Licensure Survey conducted by the Indiana State Department of Health at this facility on January 9, 2012.</p>		

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	<p>accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/09/12</p> <p>Facility Number: 000442 Provider Number: 155621 AIM Number: 100266510</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Pine Haven Health and Rehabilitation 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), and 410 IAC 16.2. The Stocker Addition II was surveyed with Chapter 18 New Health Care Occupancies.</p> <p>This portion of the facility was one story and determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridors, and all resident</p>				

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K0048 SS=F	<p>rooms. The facility has a capacity of 120 and had a census of 100 at the time of this survey.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>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 complete written fire safety plan for the protection of 100 of 100 residents in the event of an emergency addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan 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 	K0048	<p><i>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</i></p> <p>Upon orientation, all new employees will receive instruction on the use of ABC-type fire extinguishers. In addition, dietary employees will also receive instruction on the use of the K-class fire extinguishers. This instruction will be done by the Maintenance Director or his designee during the tour of the facility. Current employees will continue to receive fire safety training at least annually.</p>	02/08/2012

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	<p>(8) Extinguishment of fire This deficient practice could affect all occupants in the event of an emergency.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire safety plan in the Emergency Preparedness Plan on 01/09/12 at 10:55 a.m. with the Director of Maintenance present, the fire safety plan did not address how to use the ABC type fire extinguishers located throughout the building, or mention the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on an interview at the time of record review, the Director of Maintenance acknowledged the written fire safety plan did not include how to use the ABC type fire extinguishers, or mention the kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using the K class fire extinguisher.</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. 18.7.1.2</p> <p>1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Maintenance Inservice Book on 01/09/12 at 10:00 a.m. with the Director of Maintenance present, the facility lacked written documentation a fire drill was conducted during the third (night) shift of the first quarter (January, February, and March) of 2011. This was acknowledged by the Director of Maintenance at the time of record review.</p>	K0050	<p>K 050</p> <p><i>The corrective action accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>1. The Maintenance Director responsible for fire drills during first quarter of 2011 is no longer employed here. The current Maintenance Director is aware of the required frequency of fire drills. Written documentation is maintained in the Maintenance office.</p> <p>2. Fire drills will be held at varied times on each shift. Documentation maintained in Maintenance office.</p> <p>3. Complete documentation of the transmission of the fire alarm signal to the monitoring company will be obtained for all fire drills. On January 19, 2012, Administrator and Maintenance Director met with Robert Horton of Priority One Fire & Security to discuss procedure for verifying transmission of drills. The Maintenance Director will request faxed verification of fire alarm signal</p>	02/08/2012	

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	<p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 3 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Maintenance Inservice Book on 01/09/12 at 10:00 a.m. with the Director of Maintenance present, three of four first shift (day) fire drills since January of 2011 were performed between 1:30 p.m. and 2:40 p.m., three of four second shift (evening) fire drills since January of 2011 were performed between 3:55 p.m. and 4:05 p.m., and four of four third shift (night) fire drills since January of 2011 were performed between 6:15 a.m. and 6:45 a.m. During an interview at the time of record review, the Director of Maintenance acknowledged the times of the first, second, and third shift fire</p>		<p>transmission following each fire drill. A report will be emailed to the Administrator the first of each month that verifies the transmission of previous month's fire alarm signals. These reports will be reconciled monthly.</p> <p><i>How other residents having the potential to be affected will be identified and what corrective action will be taken:</i></p> <p>N/A</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</i></p> <p>Maintenance Director will obtain documentation of transmission of the fire alarm signal to the monitoring company following all fire drills.</p> <p><i>How the corrective action will be monitored, i.e., what quality assurance program will be put into place:</i></p> <p>This documentation will be maintained in the Maintenance office.</p>		

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	<p>drills.</p> <p>3-1.19(b)</p> <p>3. Based on record review and interview, the facility failed to ensure each documented fire drill included complete documentation of the transmission of a fire alarm signal to the monitoring company for 2 of 12 drills. LSC 19.7.1.2 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills since January of 2011 in the Maintenance Inservice Book on 01/09/12 at 10:00 a.m. with the Director of Maintenance present, two of the twelve documented fire drill reports dated 01/31/11 and 02/02/11 did not include information the monitoring company received the transmission of the alarm. During an interview at the time of record</p>				

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K0052 SS=F	<p>review, the Director of Maintenance indicated the monitoring company was always contacted before and after a fire drill was conducted during all shifts, but acknowledged the two fire drill reports did not include this information.</p> <p>3-1.19(b)</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure 8 of 102 smoke detectors were tested annually. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors be tested annually. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's quarterly fire alarm system</p>	K0052	<p>K 052 <i>The corrective action accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>Maintenance Director and Administrator met with Robert Horton of Priority One Fire & Security on January 19, 2012 and determined all 102 smoke detectors were, in fact, tested annually. The missing reports were due to a clerical error on the part of the testing service. The documentation will be provided by the testing service.</p> <p><i>How other residents having the potential to be affected will be identified and what corrective action will be taken:</i></p> <p>N/A</p>	02/08/2012	

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K0062 SS=E	<p>inspection reports in the Maintenance Inservice Book on 01/09/12 at 1:50 p.m. with the Director of Maintenance present, the four most recent quarterly fire alarm system inspection reports dated 02/08/11, 05/05/11, 08/26/11, and 11/28/11 had a total of ninety four smoke detectors tested visually and functionally. The most recent smoke detector sensitivity test dated 11/22/10 indicated one hundred two smoke detectors were tested and passed. That left eight smoke detectors unaccounted for during the past four quarterly fire alarm system inspections. During an interview at the time of record review, the Director of Maintenance acknowledged the number of smoke detectors listed in the quarterly fire alarm system reports and the most recent sensitivity test report were not consistent.</p> <p>3-1.19(b)</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p>		<p><i>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</i> N/A</p> <p><i>How the corrective action will be monitored, i.e., what quality assurance program will be put into place:</i> Maintenance Director will maintain the quarterly fire alarm system inspection reports in the Maintenance office and reconcile the documented number of smoke detectors tested with the number of smoke detectors in the facility.</p>	

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	<p>Based on observation and interview, the facility failed to ensure 5 of 5 sprinkler heads under the attached Stocker II sunporch were free of corrosion. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be free of corrosion. Any sprinkler shall be replaced that is corroded. This deficient practice could affect 16 residents, as well as staff and visitors while using or traversing the Stocker II sunporch.</p> <p>Findings include:</p> <p>Based on observation on 01/09/12 at 1:30 p.m. during a tour of the facility with the Director of Maintenance, all five sprinkler heads under the Stocker II sunporch were covered with green corrosion. This was acknowledged by the Director of Maintenance at the time of observation.</p> <p>3.1 – 19(b)</p>	K0062	<p>K 062</p> <p><i>The corrective action accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>The five sprinkler heads under the attached Stocker II sunporch will be replaced . Southwestern Sprinkler has been contracted to complete this work.</p> <p><i>How other residents having the potential to be affected will be identified and what corrective action will be taken:</i></p> <p>N/A</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</i></p> <p>Maintenance Director and/or his designee will visually inspect sprinkler heads to ensure they are free of corrosion that may affect their proper operation.</p> <p><i>How the corrective action will be monitored, i.e., what quality assurance program will be put into place:</i></p> <p>N/A</p>	02/08/2012	