STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155551	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 07/08/2014
NAME OF PROVIDER OR SUPPLIER ROLLING MEADOWS HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 604 RENNAKER ST LA FONTAINE, IN 46940	

(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: 07/08/14 Facility Number: 000447 Provider Number: 155551 AIM Number: 100289950 Surveyor: Dennis Austill, Life Safety Code Specialist At this Life Safety Code survey, Rolling Meadows Health Care 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. 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 hard wired smoke detectors in the corridors, in areas open to the corridors and in the resident rooms. The facility has a capacity of 115 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 90 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had three detached sheds providing facility services including the storage of maintenance supplies, activity supplies and wheel chairs that were not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/14/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
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 record review and interview; the facility failed to ensure 1 of 1 battery operated emergency lights in the facility was maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment requires an annual test to be conducted on every required battery powered emergency	K010046	**CORRECTIVE ACTIONS:** *No residents were negatively affected. The90 minute, annual test for the battery operated light at the generator has beentested and is in working condition.* **IDENTIFICATION OF AND CORRECTIVEACTIONS TAKEN FOR OTHER RESIDENTS**	08/07/2014

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	lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors throughout the facility. Findings include: Based on review of generator testing documentation which included a test of the battery operated generator task light and interview with the Administrator on 07/08/14 at 11:00 a.m., the annual 90 minute test for the battery operated light located at the generator was not documented. 3.1-19(b)		**HAVING THE POTENTIAL TO BE AFFECTED BY THEALLEGED PRACTICE:** *All residents hadthe potential to be affected. The battery operated light at the generator hasbeen tested and is in proper working condition and will illuminate.* **MEASURES TAKEN TO AND SYSTEMATICCHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT REOCCUR:** *Thetesting and monitoring of the battery operated light at the generator has beenadded to the TELS monitoring system for further annual inspection andmonitoring. Maintenance supervisor and assistant reeducated on the frequencyand documentation requirements of the battery operated light at the generator.* **HOW THE CORRECTIVE ACTIONS WILLBE MONITORED AND THE QA SYSTEM IMPLEMENTED TO ENSURE THE ALLEGED DEFICIENTPRACTICE DOES NOT REOCCUR:** *Themaintenance director or designee will monitor and inspect the battery operatedlight at the generator on an annual basis. All concerns will be forwarded bythe maintenance director to the Health Facility Administrator and the QAAcommittee for further response and monitoring for*	

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			compliance. **CORRECTIONS COMPLETED:** *Correctionswere completed by August 7, 2014.*	
K010047 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to ensure 1 of 2 exit signs within the Loretta Lane unit was continuously illuminated. This deficient practice had the potential to affect at least 10 residents, staff and visitors in the Loretta Lane unit. Findings include: Based on observation with the Maintenance Director on 07/08/14 from 10:00 a.m. to 12:00 p.m., the exit sign at the inside of the Loretta Lane unit entrance near the nurse's station was not illuminated. Based on interview at the time of observation, the Maintenance Director acknowledged the exit sign was not illuminated. 3.1-19(b)	K010047	**K 047:** **CORRECTIVE ACTIONS:** *No residents were negatively affected. Theexit sign light bulb has been replaced with a working, illuminated light.* **IDENTIFICATION OF AND CORRECTIVEACTIONS TAKEN FOR OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THEALLEGED PRACTICE:** *All residents onLoretta Lane had the potential to be affected. All exit signs within thefacility have been inspected with no further issues. All exit lights areilluminated and in proper working condition.* **MEASURES TAKEN TO AND SYSTEMATICCHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT REOCCUR:** *All exit signs are illuminated and workingappropriately. Maintenance director and assistant re-educated on*	08/07/2014

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			illuminationof exit signs. **HOW THE CORRECTIVE ACTIONS WILLBE MONITORED AND THE QA SYSTEM IMPLEMENTED TO ENSURE THE ALLEGED DEFICIENTPRACTICE DOES NOT REOCCUR:** *Themaintenance director or designee will monitor and inspect Exit signs on amonthly basis. All concerns will be forwarded by the maintenance director tothe Health Facility Administrator and the QAA committee for further responseand monitoring for compliance.* **CORRECTIONS COMPLETED:** *Corrections were completed by August 7,2014.*	
K010050 SS=C	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 1. Based on record review and interview, the facility failed to ensure 4 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station. This deficient	K010050	**CORRECTIVE ACTIONS:** *Noresidents were affected. The maintenance director and maintenance assistantwere inserviced on the Life Safety Code regulations pertaining to the*	08/07/2014

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	practice affects all residents in the facility as well as staff and visitors. Findings include: Based on review of Monthly Fire Drill Reports on 07/08/14 from 10:00 a.m. to 12:00 p.m. with the Administrator, the documentation for the drills performed on 03/13/14, 12/17/13, 11/30/13 and 10/29/13 indicated the fire alarm was activated but lacked verification of the transmission of the fire alarm signal. Based on interview at the time of record review, the Administrator acknowledged the transmission of the fire alarm signal to the monitoring station was not documented for the aforementioned fire drills. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to ensure 10 of 12 fire drills were conducted under varied conditions. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on review of Monthly Fire Drill Reports on 07/08/14 from 10:00 a.m. to		*"varyingconditions" of monthly fire drills. The maintenance director and assistant wereinserviced on obtaining "verification of transmission of the fire alarm signalto the monitoring station.* **IDENTIFICATION OF AND CORRECTIVEACTIONS TAKEN FOR OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THEALLEGED PRACTICE:** *All residents hadthe potential to be affected. Verification of transmission for the missingmonthly fire alarms were obtained from the monitoring company. Ongoing monthlyfire drills will be monitored by the administrator to ensure "varyingconditions" are occurring.* **MEASURES TAKEN TO AND SYSTEMATICCHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT REOCCUR:** *The monthly fire drill/alarm report has beenmodified to ensure documentation from the monitoring company that theverification of transmission has been received. The yearly fire drillschedule/audit tool has been modified to ensure "varying conditions" willoccur. Health Facility Administrator will initial completed form indicatingreview.* **HOW THE CORRECTIVE**	

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	12:00 p.m. with the Administrator, the following was noted: a. 10 of 12 fire drills conducted over the past four quarters were conducted near the end of the month: 1/29/14, 2/28/14, 3/31/14, 4/30/13, 5/30/13, 6/30/13, 7/31/13, 8/29/13, 10/29/13 and 11/30/13. b. 4 of 4 first shift fire drills conducted over the past four quarters were not held at random times; on 1/29/14 at 1:50 p.m., on 4/30/14 at 1:55 p.m., on 7/31/13 at 1:15 p.m. and on 10/29/13 at 1:35 p.m. Based on interview at the time of record review, the aforementioned conditions were acknowledged by the Administrator. 3.1-19(b) 3.1-51(c)		**ACTIONS WILLBE MONITORED AND THE QA SYSTEM IMPLEMENTED TO ENSURE THE ALLEGED DEFICIENTPRACTICE DOES NOT REOCCUR:** *Themaintenance director or designee will ensure verification of transmission ofsignal to the monitoring company has occurred each month during the testing ofthe fire drills. The maintenance director or designee will also ensure monthlyfire drills are conducted under varying conditions. All concerns will beforwarded by the maintenance director to the Health Facility Administrator andthe QAA committee for further response and monitoring for compliance.* **CORRECTIONS COMPLETED:** *Correctionswere completed by August 7, 2014.*	
K010051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of			

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	tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6			
	Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control panels, located in an area that was not continuously occupied, was provided with automatic smoke detection to ensure notification of a fire at that location before it is incapacitated by fire. LSC 9.6.2.10 refers to NFPA 72, the National Fire Alarm Code. NFPA 72 at 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to provide notification of a fire in that location. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observation on 07/08/14 from 12:00 p.m. to 2:00 p.m. with the Maintenance Director, the fire alarm control panel (FACP) was located in the mechanical/sprinkler riser room and was not provided with automatic smoke detection. Based on interview at the time of observation, the Maintenance Director acknowledged the FACP had been	K010051	**CORRECTIVE ACTIONS:** Noresidents were affected. A monitoring device was placed in the sprinkler roomwhere the fire alarm control panel is located. **IDENTIFICATION OF AND CORRECTIVEACTIONS TAKEN FOR OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE ALLEGEDPRACTICE:** There is currently only one fire alarm control panel in thefacility. A monitoring device has been placed in the sprinkler room where thefire alarm control panel is located to provide continuous monitoring. **MEASURES TAKEN TO AND SYSTEMATICCHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT REOCCUR:** A monitoring device has been placed in thesprinkler room where the fire alarm control panel is located to providecontinuous monitoring. **HOW THE CORRECTIVE ACTIONS WILLBE MONITORED AND THE QA SYSTEM IMPLEMENTED TO ENSURE**	08/07/2014

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	relocated last fall from the front nurses station to the mechanical/sprinkler riser room as part of a renovation project. 3.1-19(b)		**THE ALLEGED DEFICIENTPRACTICE DOES NOT REOCCUR:** *Thecontinuous monitoring device will provide observation to the sprinkler roomwhich is not continuously occupied. All concerns will be forwarded by themaintenance director to the Health Facility Administrator and the QAA committeefor further response and monitoring for compliance.* **CORRECTIONS COMPLETED:** *Correctionswere completed by August 7, 2014*	
K010062 SS=C	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 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. NFPA 25, 7-3.4	K010062	**CORRECTIVE ACTIONS:** Noresidents were negatively affected. The sprinkler head in the walk inrefrigerator has been removed and a new, properly working sprinkler head wasinstalled. The clothing items have been hung in a different location in theactivity storage area. **IDENTIFICATION OF AND CORRECTIVEACTIONS TAKEN FOR OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THEALLEGED PRACTICE:** No other residents have the potential	08/07/2014

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	requires system piping, fittings, hangers, and supports shall be inspected and maintained to ensure continuity of water delivery to the spray nozzles at full waterflow and design pressure. NFPA 25, A-7-3.4 states the operation of the water spray system is dependent on the integrity of the piping, which should be kept in good condition and free of mechanical damage. The pipe should not be used for support of ladders, stock, or other material. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Maintenance Director from 12:00 p.m. to 2:00 p.m. on 07/08/14, the following was noted: a. One of one sprinkler heads in the walk-in refrigerator was loaded with dust. b. A two foot section of sprinkler pipe in the activity storage area in the attached storage area behind the kitchen was used to support at least eleven clothing items/costumes hung on hangers. Based on interview during the times of the observations, the Maintenance Director acknowledged sprinkler pipe was used to support hangers of clothing and the sprinkler head in the walk-in refrigerator was loaded with dust in the aforementioned areas.		to be affected. Thewalk in refrigerator has a new sprinkler head and protective cage that has beenadded. All clothing items on hangers have been properly hung in a differentlocation. **MEASURES TAKEN TO AND SYSTEMATICCHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT REOCCUR:** Allsprinkler heads in the facility have been audited for compliance with nofurther findings. Sprinkler pipes throughout the facility have been audited forcompliance with no further findings. The activities staff were re-inserviced onappropriate storage of clothing items. **HOW THE CORRECTIVE ACTIONS WILLBE MONITORED AND THE QA SYSTEM IMPLEMENTED TO ENSURE THE ALLEGED DEFICIENTPRACTICE DOES NOT REOCCUR:** *Sprinklerheads and sprinkler pipe will be monitored on an ongoing basis for compliance. Allconcerns will be forwarded by the maintenance director to the Health FacilityAdministrator and the QAA committee for further response and monitoring forcompliance.* **CORRECTIONS COMPLETED:** *Corrections were completed by August 7, 2014*	

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	3.1-19(b)			
K010066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (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. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (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 Based on observation and interview, the facility failed to failed to ensure cigarette butts were deposited into a noncombustible container which was provided and ensure trash and cigarette butts in 1 of 1 areas where smoking was permitted for staff were not commingled. This deficient practice could affect staff	K010066	**CORRECTIVE ACTIONS:** *No residents had the potential to benegatively affected due to the designated employee smoking area is not onfacility property. The smoke tower in the designated employee smoking area wasproperly cleaned and the trash has been removed. The area surrounding thedesignated*	08/07/2014

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	using the smoking area. Findings include: Based on observation with the Maintenance Director during a tour of the facility on 07/08/14 from 12:00 p.m. to 2:00 p.m., a smoke tower container at the designated smoking area for staff outside the facility contained cigarette butts commingled with paper trash. Additionally, there were discarded cigarette butts on the ground around the designated smoking area and near the front of the maintenance shed. Based on interview at the time of observation, the Maintenance Director acknowledged the commingled trash and cigarette butts. 3.1-19(b)		*smoking area for staff has additionally been cleaned and discardedcigarette butts have been properly disposed of.* **IDENTIFICATION OF AND CORRECTIVEACTIONS TAKEN FOR OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THEALLEGED PRACTICE:** *No residents havethe potential to be affected due to the designated employee smoking area notbeing on facility property. The smoke tower and surrounding area has beenproperly cleaned. Health Facility Administrator spoke with the property managerregarding cleanliness and presentation of their property.* **MEASURES TAKEN TO AND SYSTEMATICCHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT REOCCUR:** *Afacility wide inservice was created and employees were re-educated on thefacility smoking policy. All employees have been notified of the designatedsmoking area and the facility "no smoking" policy.* **HOW THE CORRECTIVE ACTIONS WILLBE MONITORED AND THE QA SYSTEM IMPLEMENTED TO ENSURE THE ALLEGED DEFICIENTPRACTICE DOES NOT REOCCUR:** *Thedesignated*	

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			smoking area will be monitored on an ongoing basis for cleanlinessand trash in the smoke tower. All concerns will be forwarded by the maintenancedirector to the Health Facility Administrator and the QAA committee for furtherresponse and monitoring for compliance. **CORRECTIONS COMPLETED:** *Corrections were completed by August 7, 2014*	
K010130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, interview and record review; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written	K010130	**CORRECTIVE ACTIONS:** *Noresidents were negatively affected. The annual rolling fire door inspection wascompleted.* **IDENTIFICATION OF AND CORRECTIVEACTIONS TAKEN FOR OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THEALLEGED PRACTICE:** *No other residentshad the potential to be affected as the rolling fire door is located in thekitchen.* **MEASURES TAKEN TO AND SYSTEMATICCHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT REOCCUR:** *Therolling fire door was inspected. The maintenance director and assistant werere-educated on the*	08/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155551	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 07/08/2014
NAME OF PROVIDER OR SUPPLIER ROLLING MEADOWS HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 604 RENNAKER ST LA FONTAINE, IN 46940	

(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
	record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any resident using the main dining room adjacent to the kitchen including staff or visitors. Findings include: Based on record review on 7/08/14 from 10:00 a.m. to 12:00 p.m. with the Administrator, the documentation for inspection of the rolling fire door in the kitchen was dated 6/7/13. Based on observation during the tour from 12:00 p.m. to 2:00 p.m. with the Maintenance Director, the rolling fire door protecting the opening from the kitchen to the main dining room had an attached inspection tag also last dated 6/7/13. Based on interview at the time of record review and observation, the Administrator and Maintenance Director acknowledged there was no documentation of an annual inspection or test since 6/7/13 to check for proper operation and full closure of the vertical rolling fire door. 3.1-19(b)		*timeliness of the rolling fire door inspection. Theinspection company was notified of the deficient practice and annual test wascompleted outside of a twelve month window.* **HOW THE CORRECTIVE ACTIONS WILLBE MONITORED AND THE QA SYSTEM IMPLEMENTED TO ENSURE THE ALLEGED DEFICIENTPRACTICE DOES NOT REOCCUR:** *An rollingfire door inspection will be completed on an annual basis. The TELS monitoringsystem will ensure the annual test is completed and the Health FacilityAdministrator will initial form to ensure accuracy and completion. All concernswill be forwarded by the maintenance director to the Health FacilityAdministrator and the QAA committee for further response and monitoring forcompliance.* **CORRECTIONS COMPLETED:** *Correctionswere completed by August 7, 2014*	