

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155270	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 09/10/2013
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NAME OF PROVIDER OR SUPPLIER CORE OF HUNTINGBURG INC	STREET ADDRESS, CITY, STATE, ZIP CODE 510 W MEDCALF DALE, IN 47523
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K020000	<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: 09/10/13</p> <p>Facility Number: 000170 Provider Number: 155270 AIM Number: 100287490</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Core of Huntingburg, Inc. was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and in spaces open to the corridors, plus battery operated smoke detectors in all resident</p>	K020000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>sleeping rooms. The facility has a capacity of 60 and had a census of 48 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a detached laundry building.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/17/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K020029 SS=F	<p>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</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 doors to the kitchen, hazardous area doors, were equipped with positive latches and latched into their door frames. This deficient practice could affect all residents, as well as staff and visitors while in the dining room which was large enough to seat all residents.</p> <p>Findings include:</p> <p>Based on observations on 09/10/13 between 1:15 p.m. and 1:20 p.m. during a tour of the facility with the Environmental Supervisor and the Maintenance Supervisor, the main kitchen door and the kitchen service door/window between the kitchen and dining room were not provided with positive latches. Both were equipped with deadbolt latches only. This was acknowledged by the Environmental</p>	K020029	<p>K0029-Its the our policy to to ensure all doors to kitchen, and other hazardous area doors, are equipped with positive latches and latched into their door frames. This effected residents while in Dining Room area.Systemic changes: Changed knobs to Kitchen door, which are standard knobs which have the locks. Also the kitchen service doors' knob was replaced with a standard doorknob with a lock and closer.Institute a policy/procedure concerning deficiency which will be placed into inspection book.Environmental supervisor/maintainence will be responsible monthly inspections on all doorknobs in facility and recording date and condition of said locks in Inspeccion book.</p>	09/30/2013			

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	Supervisor and the Maintenance Supervisor at the time of each observation. 3.1-19(b)				

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K020038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure not more than one delayed egress lock device complying with NFPA 101, 7.2.1.6.1 was provided in any egress path as permitted by NFPA 101, 19.2.2.2.4, Exception No. 2 in 1 of 5 egress paths. This deficient practice could affect 27 residents, as well as staff and visitors in the West Unit.</p> <p>Findings include:</p> <p>Based on observation on 09/10/13 at 12:45 p.m. during a tour of the facility with the Environmental Supervisor and the Maintenance Supervisor, the egress path of exit from the West Unit exit door was provided with a delayed egress lock, furthermore, the path to egress away from the building from this exit door was through a gate which was also equipped with a delayed egress lock. This was acknowledged by the Environmental Supervisor and the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K020038	<p>K0038- It is our Policy so that exits are readily accessible at all times in accordance with section 7.1 19.2.1. We were found to be deficient due to West Unit has a locked yard area and the exit into yard was on a delayed egress as well as the emergency only locked Gate Door. This had the potential to effect 27 residents who are lodged in the area. Systemic Changes: The delayed egress lock on exit from building into Yard now has a simple code that all can come and go thru and also is posted under the key pad as a reminder so that this exit is easily accessed. Environmental/Maintenance Supervisor to monitor and observe this exit weekly x 4 then monthly for a year and reevaluate for compliance. this data will be recorded in Inspection book.</p>	09/30/2013			

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K020046 SS=C	<p>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.</p> <p>Based on record review and interview, the facility failed to provide documentation to ensure 1 of 1 battery powered light sets was tested annually for 90 minutes. LSC 101, Section 7.9.3 requires a functional test shall be conducted annually on every required emergency lighting system for not less than 1 1/2 hours. 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. NFPA 110, 5-3-1 requires lighting at the emergency generator. This deficient practice could affect all residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the Battery Light testing log on 09/10/13 at 10:15 a.m. with the Environmental Supervisor present, there was no written documentation to show the battery powered emergency light set at the generator was tested annually for a duration of ninety minutes. The Environmental Supervisor confirmed the facility lacked a ninety minute annual test for the battery back up light set at the time</p>	K020046	It is the Policy of Core to have lighting at the emergency generator and to monitor/ inspect and keep a log with annual tests of these lights lasting 90 minutes in duration. The light that was for the emergency generator was functional at the time of survey, but no log was being recorded as to annual tests. Systemic Changes: Generator Checks are done weekly and light will be inspected for compliance at this time and logged into Inspection Book by Environmental/Maintenance Supervisor.	09/30/2013			

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	of record review. 3-1.19(b)				

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K020048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 48 of 48 residents, including staff response to battery operated smoke detectors in resident sleeping rooms, thus 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 fire safety plan in the Core Disaster Manual on 09/10/13 between 11:15 a.m. and 11:30 a.m. with the Environmental</p>	K020048	nK0048 It is the policy of CORE to have a written plan for the protection of all residents and for their evacuation in the event of an emergency. During Life Safety survey Environmental/Maintenance Supervisor provided an incomplete fire Safety Plan, from an outdated Disaster Manual. Systemic Changes: Located current/updated Disaster manual with a complete fire safety plan. To send attachments for this Fire Safety show compliance with all necessary procedures mentioned in the deficiency Tag. Environmental/Maintenance Supervisor oriented and educated as to location of current manual being in Owners office. Supervisor will disposed of incomplete outdated manuals that were in her office.	09/30/2013			

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	Supervisor present, the plan did not address staff reaction to resident room battery operated smoke detectors if actuated. Based on interview at the time of record review, the Environmental Supervisor acknowledged the fire safety plan was not a complete plan. 3.1-19(b)						

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K020050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>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 Drill book on 09/10/13 at 9:45 a.m. with the Environmental Supervisor present, the facility lacked written documentation a fire drill was conducted during the third shift (night) of the third quarter (July, August, and September) of 2012. This was acknowledged by the Environmental Supervisor at the time of record review.</p> <p>3.1-19(b)</p>	K020050	<p>K0050- It is our Policy to hold fire drills at unexpected times under varying conditions no less than one per shift quarterly, and that staff is familiar with procedures and is aware that the drills are part of established routine. At the time of survey there was no record of third shift drill being done during the third quarter. Systemic Changes: Third shift fire drill for third quarter of 2012 not recorded. Orientation/education of records of drills must be kept for the previous year. Fire Safety drills Log Binder to be brought to quarterly Quality assurance meetings by Environmental Supervisor who will report on compliance and staff performance during each shift drills.</p>	09/30/2013	

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K020062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of over 400 sprinkler heads in the facility 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 paint and corrosion. Any sprinkler shall be replaced that is painted or corroded. This deficient practice could affect any number of residents, staff and visitors while in the center corridor which includes two resident rooms, two shower rooms, the employee lounge and access to the dining room.</p> <p>Findings include:</p> <p>Based on observation on 09/10/13 at 1:25 p.m. during a tour of the facility with the Environmental Supervisor and the Maintenance Supervisor, the sprinkler head in the housekeeping closet was covered with corrosion. This was acknowledged by the Environmental Supervisor and the Maintenance Supervisor at the time of observation.</p>	K020062	<p>K0062-It is the policy of CORE to ensure that sprinkler heads are free of corrosion. It is also our policy that automatic sprinkler head storage cabinet are stocked with at least 2 of each type. During survey we were found to have over 6 sprinkler heads stored in the cabinet but none were designed for the heads located in area of West smoking exit door. Systemic Changes: The specific fire system repair company has inspected and given estimate for needed repairs, which has now been approved by Administrator/Owner. The service has been ordered and we are awaiting repair. Environmental Supervisor will now be doing monthly building inspection audits and the sprinkler heads will be checked for corrosion and Heads in storage cabinet will be counted and recorded to meet compliance.</p>	09/30/2013			

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler head storage cabinets was provided with at least two of each type of sprinkler head used in the facility. NFPA 25, 2-4.1.4 requires a minimum of two sprinklers of each type and temperature rating installed shall be stored in a cabinet on the premises for replacement purposes. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 09/10/13 between 12:00 p.m. and 2:15 p.m. during a tour of the facility with the Environmental Supervisor and the Maintenance Supervisor, the spare sprinkler head cabinet in the facility had more than six spare sprinkler heads, however, there were no green vial sidewall heads (observed outside the west exit smoker door), green vial upright heads (observed in the kitchen), pendent type quick response sprinkler heads (located in the Physical Therapy Office and housekeeping closet), or pendent type standard response sprinkler heads (located throughout the facility). This was</p>			
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	<p>confirmed by the Environmental Supervisor and the Maintenance Supervisor at the time of observations, furthermore, the Maintenance Supervisor indicated there were no other spare sprinkler heads in the facility.</p> <p>3-1.19(b)</p>				

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K020066 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 1 areas where cigarettes were smoked. This deficient practice could affect mostly staff who smoke outside the west smoker door exit plus any other resident, staff or visitor exiting this door.</p> <p>Findings include:</p> <p>Based on observation on 09/10/13 at 1:35 p.m. during a tour of the facility with the Environmental Supervisor and the</p>	K020066	<p>K0066 It is th policy of this facility to implement smoking regulations to include 1. No smoking in this facility or in residents rooms. High risk areas such as oxygen room and housekeeping/chemical supply closets etc.are marked with a NO SMOKING sign. 2. Smoking by residents that are not responsible, must be under direct supervision. 3. Ashtrays of non-combustible materials are provided in smoking areas. 4.Metal container with self closing lids to be kept at all smoking areas and butts to be disposed of into these to</p>	09/30/2013			

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	Maintenance Supervisor, the area outside the west smoker door exit was littered with at least 25 to 50 cigarette butts. There was a container in this area to dispose of cigarette butts properly. This was acknowledged by the Environmental Supervisor and the Maintenance Supervisor at the time of observation. 3.1-19(b)		extinguish ash, and then as cooled into other container for disposal. During survey there were numerous butts littering the area outside of the Back exit that is used by employees. Systemic changes: Area cleaned, inservices to all employees. All smoking areas to be audited weekly x 4, then monthly x 4. And after this period if this deficiency continues then Smoking by employees to be reevaluated by administration.		

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K020130 SS=C	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to document the maintenance of 25 of 25 battery operated smoke detectors in resident rooms to ensure the smoke detectors are continually operable. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. This deficient practice could affect all residents, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation on 09/10/13 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Environmental Supervisor and the Maintenance Supervisor, battery operated smoke detectors were observed in all resident rooms. Based on interview with the Environmental Supervisor during record review on 09/10/13 at 10:40 a.m., the facility utilizes battery operated smoke detectors in all 25 resident sleeping rooms. Furthermore, the Environmental Supervisor indicated the batteries in the battery operated smoke detectors in all resident sleeping rooms were changed on 09/01/13, however, she</p>	K020130	<p>K0130 It is the policy of CORE to have and Maintain Smoke detectors in all rooms including resident sleeping rooms. Battery tests are checked for proper function monthly and replaced if needed. All batteries to be changed at least quarterly. During survey Environmental Supervisor unable to provide a record of scheduled checks and changes. Systemic Change: A new form created for Environmental Supervisor to record the data from scheduled monthly and quarterly checks. This form will be kept in the building inspection Log Binder and used as a record for Quality/Safety of Smoke detectors serviced.</p>	09/30/2013			

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	<p>indicated there was no written documentation to show monthly tests of each battery operated smoke detector, or documentation to show the batteries were changed on 09/01/13.</p> <p>3.1-19(b)</p>			

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K020143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transferring takes place was provided with mechanical ventilation. This deficient practice could affect any number of residents, staff and visitors while in the center corridor which includes two resident rooms, two shower rooms, the employee lounge and access to the dining room.</p> <p>Findings include:</p> <p>Based on observation on 09/10/13 at 1:30 p.m. during a tour of the facility with the Environmental Supervisor and the Maintenance Supervisor, the oxygen storage/transfer room located in the center corridor had three large liquid oxygen</p>	K020143	<p>K0143 It is the Policy of CORE that oxygen is stored in a fire-resistant construction and away from resident sleeping areas. The oxygen storage room must be mechanically ventilated, sprinklered, and have a ceramic floor. Area where oxygen stored must be marked with signs indicating that Oxygen there and no Smoking allowed. During survey it was noted that mechanical ventilation was malfunctioning. Systemic Changes: Mechanical Ventilation was repaired. Environmental Supervisor will audit mechanical ventilation weekly x 4, and then will be included on the Building Inspection Monthly and recorded in Log.</p>	09/30/2013			

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	tanks and several more E sized cylinders. There was a mechanical ventilation unit provided in the ceiling, however, the ventilation unit was not working at the time of observation. This was acknowledged by the Environmental Supervisor and the Maintenance Supervisor at the time of observation. 3.1-19(b)			

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K020154 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a written policy for the protection of 48 of 48 residents containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the fire safety plan in</p>	K020154	<p>K0154 It is the policy of this facility to immediately implement special procedures in the event that a fire alarm/sprinkler alarm becomes out-of-service for more than 4 hours over a 24 hour period. This does not have to be 4 consecutive hours but can be accumulative over the 24 hr period. This could have effected all residents and staff of facility. Systemic Changes: Revised Policy and Procedure for Sprinkler system/ Fire Watch. Posted Policy and Procedure on nursing unit. Inserved all staff on ordered procedures, location of gas and water shut off, and the appropriate Departments and Personel that are to be notified in case of an event. Emergency contact list to be placed at the West unit nurses Station in the Important Numbers book. All inservices, policies and procedures and phone numbers for contact will be kept in the CORE Disaster Manual by Environmental Supervisor. Please note the attached revised Policy and Procedure.</p>	09/30/2013			

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	<p>the Core Disaster Manual on 09/10/13 between 11:15 a.m. and 11:30 a.m. with the Environmental Supervisor present, the facility did not have available a written policy and procedure for an impaired sprinkler system. During an interview on 09/10/13 at the time of record review, the Environmental Supervisor said she could not find a Fire Watch Policy for an impaired sprinkler system.</p> <p>3.1-19(b)</p>				

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K020155 SS=C	<p>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</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 48 of 48 residents containing procedures to be followed in the event the fire alarm system has to be placed out of services for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. 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 during a malfunction of the building fire alarm system. This deficient practice could affect all occupants in the facility</p>	K020155	<p>K0155 It is the policy of this facility to immediately implement procedures in the event of a fire alarm/sprinkler alarm becomes out-of-service for more than 4 hours over a 24 hour period. This does not have to be 4 consecutive hours but can be accumulative over the 24 hr period. This could have effected all residents and staff of facility. Systemic Changes: Revised Policy and Procedure for Sprinkler system/ Fire Watch. Posted Policy and Procedure on nursing unit. Inservice all staff on ordered procedures, location of gas and water shut off, and the appropriate Departments and Personnel that are to be notified in an event. Emergency contact list to be placed at the West unit nurses Station in the Important Numbers book. All inservices, policies and procedures and phone numbers for contact will be kept in the CORE Disaster Manual by Environmental Supervisor. Please note the attached revised Policy and Procedure.</p>	09/30/2013			

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	<p>including residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of the fire safety plan in the Core Disaster Manual on 09/10/13 between 11:15 a.m. and 11:30 a.m., the facility did have a written policy and procedure for an impaired fire protection system, however, the fire watch policy and procedure did not include information to contact the Indiana State Department of Health and the local fire department plus phone numbers for each. The lack of this documentation was acknowledge by the Environmental Supervisor at the time of record review.</p> <p>3.1-19(b)</p>				