

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155532	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/06/2016
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NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401
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K 0000 Bldg. 01	<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: 09/06/16</p> <p>Facility Number: 000460 Provider Number: 155532 AIM Number: 100290620</p> <p>At this Life Safety Code survey, Bloomington Nursing 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 38</p>	K 0000	<p>This plan of correction constitutes written allegation of compliance September 23, 2016. However, submission of this plan of correction is not an admission that a deficiency exists or one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.</p> <p>This facility respectfully requests desk review to establish compliance effective September 23, 2016</p>	

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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K 0048 SS=F Bldg. 01	<p>and had a census of 35 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two detached sheds used for facility storage.</p> <p>Quality Review completed on 09/08/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 35 of 35 residents to accurately address all life safety systems such as staff response to battery operated smoke alarms in resident sleeping rooms, plus a system 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 that 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 	K 0048	<p>F048 It is the intent of this facility to maintain a written plan for the protection of all residents and their evacuation in the event of an emergency.</p> <p>WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE ALLEGED DEFICIT PRACTICE: The written plan for the protection of all residents and their evacuation in the event of an emergency has been revised to include staff response to battery operated smoke alarms in resident sleeping rooms in addition to the existing information:</p> <ol style="list-style-type: none"> 1. Use of alarms 2. Transmission of alarm to the fire department 	09/23/2016

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	<p>(6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (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 fire plan on 09/06/16 at 10:25 a.m. with the Maintenance Supervisor present, the fire plan did not address staff response to battery operated smoke alarms in all resident sleeping rooms. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the fire plan did not include staff response to battery operated smoke alarms in all resident sleeping rooms.</p> <p>3.1-19(b)</p>		<p>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> <p>HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL TAKEN: The written plan for the protection of all residents and their evacuation in the event of an emergency has been revised to include staff response to battery operated smoke alarms in resident sleeping rooms in addition to the existing information:</p> <p>9. Use of alarms 10. Transmission of alarm to the fire department 11. Response to alarms 12. Isolation of fire 13. Evacuation of immediate area 14. Evacuation of smoke compartment 15. Preparation of floors and building for evacuation 16. Extinguishment of fire.</p> <p>WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE ALLEGED DEFICIENT PRACTICE WILL NOT RECUR:</p>	

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			<p>To ensure currently compliant operations and under the direction of the Administrator and/or designee an all staff in-service on the updated fire safety plan was held on September 8, 2016 to include staff response to battery operated smoke detectors. In addition fire safety is covered in the new hire orientation and annually to include training on written plan for protection all residents and for their evacuation in the event of an emergency including staff response to battery operated smoke alarms in resident sleeping areas and the Fire Safety Evacuation Procedures Skills Checklist.</p> <p>HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E. WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:</p> <p>Effective 9/23/2016 a Quality Assurance Performance Improvement audit under the direction of the Administrator and/or Designee will be used ongoing to track that each employee receives training on the updated written plan during orientation and annually for protection of all residents and for their evacuation in the event of an emergency including staff response to battery operated smoke alarms in all resident sleeping rooms including new staff during orientation and annually. Any deficiencies will be corrected immediately and findings of the</p>	

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K 0056 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>Based on observation and interview, the facility failed to ensure steel armover sprinkler pipes in 3 of 3 smoke compartments were installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect all residents, as well as staff and visitors.</p>	K 0056	<p>QAPI audit will be submitted monthly to the QAPI Committee for further review and to ensure continuing compliance.</p> <p>K056 LIFE SAFETY CODE STANDARD It is the intent of this facility to be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7 and will ensure steel armover sprinkler pipes are installed in accordance with the requirements.</p> <p>WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE ALLEGED DEFICIT PRACTICE:</p> <p>Steel sprinkler pipe armover against the wall has been supported,</p>	09/23/2016

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	<p>Findings include:</p> <p>Based on observations on 09/06/16 between 10:30 a.m. and 11:30 a.m. during a tour of the facility with the Maintenance Supervisor, the following was noted:</p> <ul style="list-style-type: none"> a. A steel sprinkler pipe armover against the wall was three feet long and was unsupported. b. A steel sprinkler pipe armover in Room 2 was three feet long and was unsupported. c. A steel sprinkler pipe armover in the Soiled Utility room was three feet long and was unsupported. d. A steel sprinkler pipe armover in Room 5 was four feet long and was unsupported. e. A steel sprinkler pipe armover in the Boiler Room was four feet long and was unsupported. f. A steel sprinkler pipe armover in Room 8 was eight feet long and was unsupported. g. A steel sprinkler pipe armover in Room 9 was eight feet long and was unsupported. <p>This was acknowledged by the Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b)</p>		<p>armover in Room 2 has been supported, armover in soiled utility has been supported, armover in Room 5 has been supported, armover in the Boiler Room has been supported, armover in Room 8 has been supported and armover in Room 9 has been supported.</p> <p>HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL TAKEN:</p> <p>To ensure no other residents are affected by the alleged deficient practice, a qualified service provider in conjunction with Maintenance inspected the entire building identifying all unsupported armovers with cumulative horizontal length exceeding 24 inches and applied supports.</p> <p>WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE ALLEGED DEFICIENT PRACTICE WILL NOT RECUR:</p> <p>To enhance currently compliant operations and under the direction of the maintenance supervisor armovers are added to PM monthly checklist to ensure supports are in place.</p> <p>HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E. WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT</p>	

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K 0069 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust system was maintained in proper working order. NFPA 96, 10-6.5 requires inspection and testing of the total operation and all safety interlocks in accordance with the manufacturer's instructions shall be performed by qualified service personnel a minimum of once every 6 months or more frequently if required. This deficient practice could affect mostly kitchen staff, plus any residents while in the same smoke compartment as the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 09/07/16 at 10:35 a.m. during a tour of the facility with the Maintenance Supervisor, 2 of 3</p>	K 0069	<p>INTO PLACE: To ensure continuing compliance and under the direction of the maintenance supervisor armovers are added to preventative monthly checklist to ensure supports are in place. Results of the monthly PM checks will be submitted to QAPI Committee for review and to ensure continuing compliance.</p> <p>K069 It is the intent of this facility that cooking facilities are protected in accordance with 9.2.3 19.3.2.6, NFPA 96</p> <p>WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE ALLEGED DEFICIT PRACTICE: The kitchen exhaust system was serviced by qualified service personnel on 9/8/2016 to ensure proper positioning of nozzles for the kitchen range hood.</p> <p>HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL TAKEN: The kitchen exhaust system was</p>	09/23/2016

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	<p>exhaust system nozzles for the kitchen range hood were not properly positioned over the cooking equipment under the hood. The nozzles were pointed in front of the stove. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>serviced by qualified service personnel on 9/8/2016 to ensure proper position of nozzles for the kitchen range hood.</p> <p>WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE ALLEGED DEFICIENT PRACTICE WILL NOT RECUR: To enhance currently compliant operations, the kitchen exhaust system is inspected and tested in accordance with manufacturer's instructions and performed by qualified service personnel a minimum of once every 6 months and more frequently as required. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E. WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Effective September 23, 2016 under the direction of the Maintenance Supervisor a visual inspection of the position of the nozzles will occur daily x 30 days and will be been added to the monthly preventative maintenance log. Any nozzles needing adjustment will be immediately reported to the professional service provider for repair. Results of the Preventative Maintenance Log will be submitted monthly to the Quality Assurance Performance Improvement Committee for review and to ensure</p>	

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K 0070 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 portable space heating device was prohibited in areas other than staff areas. This deficient practice could affect all residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 09/06/16 at 10:30 a.m. during a tour of the facility with the Maintenance Supervisor, the dining room had a fake fire place with a portable electric space heating device installed. The heating device was not being used at the time of observation. This was verified by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K 0070	<p>continuing compliance.</p> <p>It is the intent of this facility that portable space heating devices shall not be used in all health care occupancies. WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE ALLEGED DEFICIT PRACTICE:</p> <p>The faux fireplace located in the dining room has the heating device disabled and is maintained for decorative purposes only. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL TAKEN: The faux fireplace in the dining room had the heating device disabled and is maintained for decorative purposes only. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO</p>	09/23/2016

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K 0154 SS=C Bldg. 01	<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 35 of 35 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</p>	K 0154	<p>ENSURE THAT THE ALLEGED DEFICIENT PRACTICE WILL NOT RECUR: The faux fireplace in the dining room had the heating device removed and is maintained for decorative purposes only.</p> <p>HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E. WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The faux fireplace in the dining room had the heating device removed and is maintained for decorative purposes only. No monitoring is required.</p> <p>K154 It is the intent of this facility where a required fire alarm system is out of service for more than four hours in a 24 hour period the authority having jurisdiction will be notified and fire watch will be instituted per fire watch policy.</p>	09/23/2016

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	<p>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 occupants in the facility.</p> <p>Findings include:</p> <p>Based on review of the Fire Watch Policy on 09/06/16 at 10:10 a.m. with the Maintenance Supervisor present, the facility did have a written policy and procedure for an impaired sprinkler system, however, it did not address issues required in a Fire Watch Policy such as: Notifying the Indiana State Department of Health (ISDH) and Insurance Company when the system is out of service for 4 hours or more within a 24 hour time period, plus phone numbers for both the ISDH and insurance company. This was acknowledged by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b)</p>		<p>WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE ALLEGED DEFICIT PRACTICE:</p> <p>The written Fire Watch policy containing procedures for fire watch has been updated to include notifying local fire department, insurance carrier, alarm company, building owner or manager and other authorities having jurisdiction such as such as Indiana State Department of Health and CMS along with contact numbers for each entity should a fire watch be initiated.</p> <p>HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL TAKEN:</p> <p>The written Fire Watch policy containing procedures for fire watch has been updated to include notifying local fire department, insurance carrier, alarm company, building owner or manager and other authorities having jurisdiction such as Indiana State Department of Health and CMS along with contact numbers for each entity should a fire watch be initiated.</p> <p>WHAT MEASURES WILL BE PUT INTO</p>	

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			<p>PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE ALLEGED DEFICIENT PRACTICE WILL NOT RECUR:</p> <p>Staff were in-serviced to the updated fire watch policy including notification of local fire department, insurance carrier, alarm company, building owner and/or manager, and other authorities having jurisdiction including Indiana State Department of Health and CMS along with applicable phone numbers on September 8, 2016.</p> <p>HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E. WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:</p> <p>To ensure continuing compliance and under the direction of the Administrator, employee files will be audited ongoing to ensure all staff are inserviced to the updated fire watch policy including newly hired staff as part of orientation and annually. Any deficiencies will be corrected immediately. Results of the audit will be forwarded to the Quality Assurance Performance Improvement Committee for further review and to ensure continuing compliance.</p>	

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NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401
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(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
K 0155 SS=C Bldg. 01	<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 written policy for the protection of 35 of 35 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>	K 0155	<p>K155 It is the intent of this facility where a required fire alarm system is out of service for more than four hours in a 24 hour period the authority having jurisdiction will be notified and fire watch will be instituted per fire watch policy.</p> <p>WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE ALLEGED DEFICIT PRACTICE:</p> <p>The written Fire Watch policy containing procedures for fire watch has been updated to include notifying local fire department, insurance carrier, alarm company, building owner or manager and other authorities having jurisdiction such as such as Indiana State Department of Health and CMS along with contact numbers for each entity should a fire watch be initiated.</p>	09/23/2016

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	<p>Findings include:</p> <p>Based on review of the Fire Watch Policy on 09/06/16 at 10:10 a.m. with the Maintenance Supervisor present, the facility did have a written policy and procedure for an impaired sprinkler system, however, it did not address issues required in a Fire Watch Policy such as: Notifying the Indiana State Department of Health (ISDH) and Insurance Company when the system is out of service for 4 hours or more within a 24 hour time period, plus phone numbers for both the ISDH and insurance company. This was acknowledged by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b)</p>		<p>HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL TAKEN:</p> <p>The written Fire Watch policy containing procedures for fire watch has been updated to include notifying local fire department, insurance carrier, alarm company, building owner or manager and other authorities having jurisdiction such as Indiana State Department of Health and CMS along with contact numbers for each entity should a fire watch be initiated.</p> <p>WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE ALLEGED DEFICIENT PRACTICE WILL NOT RECUR:</p> <p>Staff were in-serviced to the updated fire watch policy including notification of local fire department, insurance carrier, alarm company, building owner and/or manager, and other authorities having jurisdiction including Indiana State Department of Health and CMS along with applicable phone numbers on September 8, 2016.</p> <p>HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E. WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:</p>	

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			To ensure continuing compliance and under the direction of the Administrator, employee files will be audited monthly ongoing to ensure all staff are inserviced to the updated fire watch policy including newly hired staff as part of orientation and annually. Any deficiencies will be corrected immediately. Results of the audit will be forwarded to the Quality Assurance Performance Improvement Committee for further review and to ensure continuing compliance.	