

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
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NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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K010000	<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: 10/30/14</p> <p>Facility Number: 000250 Provider Number: 155359 AIM Number: 100289980</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Riverbend 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.</p> <p>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 smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a</p>	K010000		
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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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K010025 SS=E	<p>capacity of 66 and had a census of 45 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facilities services were sprinklered with the exception of a detached wood shed used for storage of maintenance supplies.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 11/13/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>1. Based on observation and interview, the facility failed to ensure the</p>	K010025	1. Smoke barrier walls in the west hall attic, east hall attic, the ceiling smoke barrier in the	11/29/2014

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	<p>penetrations caused by the passage of wire and/or conduit through 2 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 3 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with Maintenance Director on 10/30/14 from 2:02 p.m. to 2:05 p.m., the following smoke barrier walls had unsealed penetrations:</p> <p>a) the West hall attic smoke barrier wall had one penetration measuring three fourth inch around a water line and one fourths inch penetration around conduit</p> <p>b) the East hall attic smoke barrier wall had one penetrations measuring one fourth inch around a pipe and above the ceiling tile there was a one inch penetration around conduit</p>		<p>Beauty Salon and in the Medical record storage was sealed on 11.24.2014.</p> <p>2.No other areas were identified as having an unsealed barrier.</p> <p>3.Maintenance Director will be educated on smoke barrier guidelines. Maintenance Director/Designee will monitor attic and ceiling smoke barriers weekly on random halls for 6 months.</p> <p>4.Audits will be submitted to QAPI monthly for 6 months for review to ensure compliance and evaluated.</p> <p>5.11.29.2014</p>				

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	<p>Based on interview with the Maintenance Director at the time of observations, he acknowledged the unsealed penetrations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 1 resident in the Beauty Shop and facility staff in the storage room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and the Housekeeping Supervisor on 10/30/14 from 11:50 a.m. to 12:02 p.m., the fire caulk had dried and pulled away from the ceiling penetration in the Beauty Shop leaving an one sixteenth inch gap and there was an unsealed ceiling penetration in the resident record storage room measuring one fourth inch. Based on interview with the Maintenance Director at the time of observations, he acknowledged the unsealed penetrations.</p> <p>3.1-19(b)</p>			

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K010029 SS=E	<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 doors protecting corridor openings were smoke resistive in 1 of 1 laundry rooms. This deficient practice could affect 1 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Housekeeping Supervisor on 10/30/14 at 12:02 p.m., above and below the door knob of the corridor door entering the soiled linen area of the laundry room there was a pencil size hole. Based on an interview with the Maintenance Director at the time of observation, he acknowledged the holes in the corridor door entering the laundry room.</p> <p>3.1-19(b)</p>	K010029	<ol style="list-style-type: none"> 1. Smoke resistive soiled linen laundry door was sealed on 11.21.2014 2.No other doors were identified 3.Maintenance Director was educated on smoke resistive doors in corridors. Maintenance Director/Designee will monitor corridor doors for points of penetration weekly for 6 months 4.Audits will be submitted to QAPI for 6 monthsfor review to ensure compliance 5.November 29, 2014 	11/29/2014

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K010038 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 2 of 5 exit discharge paths were readily accessible at all times. This deficient practice could affect resident in 2 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Housekeeping Supervisor on 10/30/14 during the tour from 12:11 p.m. to 2:20 p.m., the exit discharge from the east hall exit and the south hall lead to a fenced area where the gate was locked with a combination lock. Based on an interview with the Maintenance Director and Housekeeping Supervisor at the time of observations, they were unable to provide the combination needed to open the lock in order to exit the fenced area.</p> <p>3.1-19(b)</p>	K010038	<p>1. Maintenance Supervisor and Housekeeping Supervisor was educated on combination to bike lock on courtyard fence in coordination with inside facility codes at 2:20pm on 10.30.2014</p> <p>2. No other locks were identified</p> <p>3. Maintenance Director was educated on lock combinations during orientation. Maintenance Director/Designee will monitor outer lock weekly for 6 months. Maintenance Director will educate all staff upon orientation to combinations.</p> <p>4. Audits will be submitted to QAPI for 6 months for review to ensure compliance</p> <p>5. November 29, 2014</p>	11/29/2014

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K010048 SS=C	<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 written plan that included the activation of a resident room battery operated smoke detector, evacuation of a smoke compartment and the K-Class fire extinguisher in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</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</p>	K010048	<ol style="list-style-type: none"> 1. The facility has a written plan that includes the activation of a resident room battery operated smoke detector, evacuation of a smoke compartment and the K-class fire extinguisher in the written fire plan. 2. No other areas were identified 3. Maintenance Director was educated on written fire plan. Maintenance Director/Designee will monitor fire drills monthly on alternating shifts to include smoke compartment evacuation, resident room battery operated smoke detector activation and K class extinguisher in the kitchen monthly for 6 months. Maintenance Director will educate all staff upon orientation to fire plan. 4. Audits will be submitted to QAPI for 6 months for review to ensure compliance 5. November 29, 2014 	11/29/2014

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K010050 SS=F	<p>occupants.</p> <p>Findings include:</p> <p>Based on a record review with Administrator on 10/30/14 at 2:20 p.m., the "Disaster Plan" manual did not address the following:</p> <ul style="list-style-type: none"> a) activation of a resident room battery operated smoke detector b) evacuation of a smoke compartment c) the kitchen K class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. <p>Based on interview at the time of review, the Administrator acknowledged the documentation for the aforementioned issues was not available for review.</p> <p>3.1-19(b)</p> <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</p>						

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K010066 SS=E	<p>audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Southwest Allen County Fire District Fire Drill Check Sheet" with the Administrator on 10/30/14 at 2:10 p.m., there was no record of a third shift fire drill for the third quarter of 2014. Based on an interview with the Administrator at the time of record review, no other documentation was available for review to verify this drill was conducted.</p> <p>3.1-19(b) 3.1-51(c)</p> <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</p>	K010050	<p>1.The facility ensures fire drills are conducted quarterly on each shift. A third shift fire drill will be conducted on 11.26.2014.</p> <p>2.No other drills were identified.</p> <p>3.Maintenance Director was educated on fire drillguidelines. Maintenance Director/Designewill monitor fire drills monthly on alternating shifts monthly for 6 months. Maintenance Director will educate all staff upon orientation to fire plan.</p> <p>4.Audits will be submitted to QAPI for 6 monthsfor review to ensure compliance</p> <p>5.November 29, 2014</p>	11/29/2014	

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	<p>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 2 of 2 area where smoking was permitted for staff and residents were maintained and the metal container with a self-closing cover was used for an ashtray. This deficient practice could affect all residents and facility staff in the smoking area in the event of any emergency.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Housekeeping Supervisor on 10/30/14 at 11:39 a.m. and 12:34 p.m., the designated smoking areas were provided with a "smokers oasis" which is a metal container with a long neck used for cigarette butts. At least 25 cigarette butts were observed on the ground in the staff smoking area with several cigarette butts discarded in a pile</p>	K010066	<p>1. The facility ensures areas where smoking is permitted for staff and residents are maintained and the metal container with a self -closing cover is used for an ashtray. Cigarette butts in unpermitted areas were removed on October 30,2014.</p> <p>2.All other areas were free from debris.</p> <p>3.Maintenance Director was educated on maintaining outside environment. Maintenance Director/Designee will monitor cigarette butts in unpermitted areas 3 times weekly for 6 months. Maintenance Director will educate all staff upon orientation to smoking regulations.</p> <p>4.Audits will be submitted to QAPI for 6 months for review to ensure compliance</p> <p>5.November 29, 2014</p>	11/29/2014

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K010143 SS=E	<p>of dry leaves, and at least 50 cigarette butts were observed on the wood deck in the resident's smoking area. Based on an interview with the the Maintenance Supervisor and Housekeeping Supervisor at the time of observations, they acknowledged the cigarette butts had been discarded on the ground instead of the metal container.</p> <p>3.1-19(b)</p> <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 areas used for transferring of oxygen was provided</p>	K010143	1. The facility ensures that an area used for transferring oxygen is provided with continuous mechanical ventilation. Roof fan	11/29/2014

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K010144 SS=F	<p>with continuous mechanical ventilation. This deficient practice could affect 1 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director and the Housekeeping Supervisor on 10/30/14 at 12:59 p.m., the mechanical ventilation in the oxygen transfilling/storage room which contained at least six large stationary container of liquid oxygen was not working. Based on interview at the time of observation, the Maintenance Director confirmed the oxygen room mechanical vent was not working.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to maintain 1 of 1 generators in proper working order. NFPA 110, The Standard for Emergency and Standby Power Systems, Section 6-3.1, states the emergency power supply system (EPSS) shall be maintained to ensure to a reasonable degree that the</p>	K010144	<p>operating ventilation will be replaced on 11.25.2014.</p> <p>2.No other areas requiring ventilation identified</p> <p>3.Maintenance Director was educated on mechanical ventilation in oxygen room. MaintenanceDirector/Designee will monitor mechanical ventilation weekly for 6 months.</p> <p>4.Audits will be submitted to QAPI for 6 months for review to ensure compliance</p> <p>5.November 29, 2014</p> <p>1. The facility maintains a generator in proper working order. and is maintained to ensur to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. A generator contractor reviewed the system and provided maintenance to facility generator</p>	11/29/2014			

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	<p>system is capable of supplying service within the time specified for the type and for the time duration specified for the class. NFPA 110, Section 6-4.7 states, the routine maintenance and operational testing program shall be overseen by a properly instructed individual. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation, with the Administrator, Maintenance Director and Housekeeping Supervisor on 10/30/14 at 1:39 p.m., these staff members were unable to manually start the generator. After receiving instruction from the surveyor, the Maintenance Director was able to start the generator. While the generator was running the "high voltage battery trouble light was illuminated. Based on an interview with the Maintenance Director at the time of observation, he was not aware of an issue with the generator and had not received any generator training.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was inspected on a weekly basis. NFPA 99, 3-5.4.2 requires a written record or inspection,</p>		<p>on November 25, 2014. Generator was in working order, no residents had the potential of being affected. Maintenance Director was educated on weekly generator inspections. Maintenance Director/Designee will monitor generator weekly and give audits to Executive Director weekly for review for 6 months. Audits will be submitted to QAPI for 6 months for review to ensure compliance. November 29, 2014</p>		

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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			
K010154 SS=C	<p>performance, exercise period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 99, 3-4.1.1(b)1 requires generating testing be in accordance with NFPA 110, Standard for Emergency and Standby power Systems, Chapter 6. NFPA 110, 6-4.1 requires Level 1 and Level 2 EPSS including all appurtenant components shall be inspected weekly. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a review of the TEL'S generator log with the Administrator on 10/30/11 at 1:58 a.m., a weekly inspection had not been conducted since 09/12/14. Based on an interview with the Administrator at the time of observation, she was unable to provide documentation to confirm the weekly checks had been conducted.</p> <p>3.1-19(b)</p> <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</p>						

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	<p>sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to protect 45 of 45 residents by providing a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for more than 4 hours in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC, Section A.9.7.6 explains the individual conducting the fire watch should be specially trained in fire prevention, in the use of fire extinguishers, in notifying the fire department, in sounding the building fire alarm and in understanding the particular fire safety situation for public education purposes. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Fire Watch Policy" with the Administrator on 10/30/14 at 1:50 p.m., the facility did have a written policy and procedure for an impaired sprinkler system available for review, but the policy did not state the designated person(s) conducting the fire watch shall be properly trained in the fire watch procedures. The Administrator confirmed the fire watch policy documentation lacked a statement</p>	K010154	<p>1. The facility provides a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for more than 4 hours in a 24 hour period explaining the individual conducting the fire watch should be specially trained in fire prevention, in the use of fire extinguishers, in notifying the fire department, in sounding the building fire alarm and in understanding the particular fire safety situation for education purposes.2. All residents had the potential to be affected3. Maintenance Director was educated on the written policy on Fire Watch. Maintenance Director will be responsible for educating all new hires and annual training. Maintenance Director will conduct fire watch drills quarterly for 6 months.4. Audits will be submitted to QAPI monthly for review to ensure compliance.5. November 29, 2014</p>	11/29/2014	

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K010155 SS=C	<p>indicating the person(s) conducting the fire watch shall be properly trained.</p> <p>3.1-19(b)</p> <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 Based on record review and interview, the facility failed to provide a complete written policy for the protection of 45 of 45 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. 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</p>	K010155	<p>1. The facility provides a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for more than 4 hours in a 24 hour period explaining the individual conducting the fire watch should be specially trained in fire prevention, in the use of fire extinguishers, in notifying the fire department, in sounding the building fire alarm and in understanding the particular fire safety situation for education purposes. 2. All residents had the potential to be affected. 3. Maintenance Director was educated on the written policy on Fire Watch. Maintenance Director will be responsible for educating all new hires and</p>	11/29/2014

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	<p>transmission of the alarm to the fire department and response to alarms.</p> <p>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 affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Fire Watch Policy" with the Administrator on 10/30/14 at 1:50 p.m., the facility did have a written policy and procedure for an impaired fire alarm system available for review, but the policy did not state the designated person(s) conducting the fire watch shall be properly trained in the fire watch procedures. The Administrator confirmed the fire watch policy documentation lacked a statement indicating the person(s) conducting the fire watch shall be properly trained.</p> <p>3.1-19(b)</p>		<p>annual training. Maintenance Director will conduct fire watch drills quarterly for 6 months.4. Audits will be submitted to QAPI monthly for review to ensure compliance.5. November 29, 2014</p>	
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