

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/09/2014
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NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150
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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
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 Dates: 07/09/14</p> <p>Facility Number: 002657 Provider Number: 155681 AIM Number: 200308930</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Autumn Woods Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies.</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 hard wired smoke detectors in the corridors, in spaces open to the corridors, and in all resident</p>	K010000		

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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K010018 SS=B	<p>sleeping rooms. The facility has a capacity of 93 and had a census of 88 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.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/21/14.</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 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS</p>						

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K010029 SS=E	<p>regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 1 sets of double doors to the corridors were equipped with positive latches and latched into the door frame. This deficient practice could affect up to 19 residents, as well as staff and visitors while in the 100 hall.</p> <p>Findings include:</p> <p>Based on observations on 07/09/14 at 1:55 p.m. during a tour of the facility with the Director of Plant Operations, the set of double doors to the 100 hall Mechanical Closet did not automatically latch positively into the door frame. They had to be manually latched with a built in slide bolt latch located at the top edge of each door. This was acknowledged by the Director of Plant Operations at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K010018	<p>1. The 400 hall mechanical closet and 400 hall electrical closet are now equipped with positive latches and latched into the door frame on 7/31/2014. This was completed by the Director of Plant Operations. 2. 37 residents, staff and visitors on 400 and 500 hall had the potential to be affected by the deficient practice. A review of the campus found 100 hall mechanical room doors and (2) sets of doors in the east dining room with manual slide bolt latches. The identified doors were corrected on 7/31/2014 and are now equipped with positive latches and latched into the door frame. 3. The Director of Plant Operations was educated by the Executive Director on 7/29/2014 on the regulatory requirement of double doors to be equipped with positive latches. 4. The Director of Plant operations will conduct an audit of double doors ensuring the positive latches are in place and functioning properly one time weekly for four weeks and then monthly for two months. Results of these audits will be presented by the Director of Plant Operations to the QA committee for further recommendations and continue until the Quality Assurance team determines substantial compliance has been achieved.</p>	08/08/2014	

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	<p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 sets of double doors to the dining room closet, hazardous area room doors, were equipped with positive latches that automatically latched into the door frames when closed. This deficient practice could affect up to 24 residents, as well as staff and visitors while in the east dining room.</p> <p>Findings include:</p> <p>Based on observation on 07/09/14 at 1:35 p.m. during a tour of the facility with the Director of Plant Operations, the two sets of double doors to the east dining room closet were not provided with positive latches that automatically latched into the door frames when closed. Both were equipped with manual slide bolt latches located at the top of each door. The east dining room closet was over fifty square</p>	K010029	<p>1. The two sets of east dining room closet doors are now equipped with positive latches and latched into the door frame on 7/31/2014. This was completed by the Director of Plant Operations.</p> <p>2. 24 residents, staff and visitors in the east dining room had the potential to be affected by the deficient practice. A review of the campus found 100 hall mechanical room doors, a set of doors at 400 halls mechanical and a set of doors at 400 electrical closets with manual slide bolt latches. The identified doors were corrected on 7/31/2014 and are now equipped with positive latches and latched into the door frame.</p> <p>3. The Director of Plant Operations was educated by the Executive Director on 7/29/2014 on the regulatory requirement of double doors to be equipped with positive latches.</p>	08/08/2014

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K010048 SS=C	<p>feet in size and filled with combustible material such as paper, plastic, cardboard, and other items. This was acknowledged by the Director of Plant Operations at the time of observation.</p> <p>3.1-19(b)</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 88 of 88 residents to accurately address all life safety systems such as the use of the K-class fire extinguisher in the kitchen 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: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms</p>	K010048	<p>4. The Director of Plant operations will conduct an audit of double doors ensuring the positive latches are in place and functioning properly one time weekly for four weeks and then monthly for two months to verify ongoing compliance. Results of these audits will be presented by the Director of Plant Operations to the QA committee for further recommendations and continue until the Quality Assurance team determines substantial compliance has been achieved.</p> <p>1. The "Fire" section of the Emergency Preparedness Manual now addresses the use of the K-class fire extinguisher in the kitchen on 7/27/2014. The Emergency Preparedness Manual now refers to "fire" without the use of the words small, major and minor to describe the size of the fire on 7/27/2014. 2. 88 of 88 residents had the potential to be affected by the deficient practice. 3. All Emergency Preparedness Manuals were updated and redistributed to each nurse's station on 7/27/14 by the Executive Director. All staff were educated on changes to manual</p>	08/08/2014

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K010050 SS=C	<p>(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 This deficient practice could affect all occupants in the event of an emergency.</p> <p>Findings include:</p> <p>Based on record review on 07/09/14 at 12:20 p.m. with the Director of Plant Operations present, the "Fire" section of the Emergency Preparedness Manual did not address the use of the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Furthermore, the use of the words "small", "major", and "minor" were used throughout the "Fire" section to describe the size of a fire. Based on interview at the time of record review, the Director of Plant Operations acknowledged the Fire plan did not address the use of the K-class fire extinguisher in the kitchen, plus the use of the words small, major, and minor to describe the size of a fire.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>				<p>regarding K-class fire extinguisher and removal of small, major and minor to describe the size of the fire. This was completed by the Executive Director. 4. The Executive Director will conduct an audit to ensure staff are able to locate an Emergency Preparedness binder three times a week for four weeks and then monthly for two months to verify ongoing compliance. Results of these audits will be presented by the Executive Director for further recommendations and continue until the Quality Assurance team determines substantial compliance has been achieved.</p>		

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	<p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure each documented fire drill included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department for 12 of 12 fire drills. LSC 19.7.1.2 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Trilogy Plant Operations Manual on 07/09/14 at 11:40 a.m. with the Director of Plant Operations present, documentation for all twelve fire drills during the past twelve months did not include information to indicate the monitoring company/fire department received the transmission of the fire alarm. Based on interview at the time of</p>	K010050	<ol style="list-style-type: none"> The campus obtained documentation of the transmission of a fire signal to the monitoring company for 12 of 12 fire drills on 7/30/2014. 88 of 88 residents had the potential to be affected by the deficient practice. Director of Plant Operations was re educated on obtaining documentation of fire signal from monitoring company after each fire drill on 7/28/2014 by the Executive Director. Director of Plant Operations will submit the fire drill reports including documentation of fire signal at monitoring company to the Executive Director monthly to verify ongoing compliance. Results of the fire drill reports will be presented by the DPO to the QA committee monthly for any recommendations and will continue until the QA committee determines that substantial compliance has been 	08/08/2014			

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K010154 SS=C	<p>record review, the Director of Plant Operations acknowledged documentation for the fire drills did not include information the monitoring company/fire department received the transmission of the fire alarm.</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 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 complete written policy for the protection of 88 of 88 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</p>	K010154	<p>achieved.</p> <p>1. The fire watch policy and procedure now includes the phone numbers for the local fire department, insurance carrier and the Indiana State Department of Health. This was completed by the Executive Director on 7/27/14.</p> <p>2. 88 of 88 residents had the potential to be affected by the deficient practice.</p> <p>3. All Emergency Preparedness Manuals were updated and redistributed to each nurse's station. All staff were re-educated on changes to manual regarding</p>	08/08/2014

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K010155 SS=C	<p>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, staff and visitors at the time of this survey.</p> <p>Findings include:</p> <p>Based on review of the Emergency Fire Watch with the Director of Plant Operations present on 07/09/14 at 12:30 p.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 phone numbers for the local fire department, insurance carrier, and the Indiana State Department of Health. The lack of this documentation was acknowledge by the Director of Plant Operations at the time of record review.</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</p>		<p>addition of phone numbers for the local fire department, insurance carrier and Indiana State Department of Health by the Executive Director on 7/23/14 and 7/24/14.</p> <p>4. The Executive Director will conduct an audit to ensure staff are able to locate an Emergency Preparedness binder three times a week for four weeks and then monthly for two months to verify on ongoing compliance. Results of these audits will be presented by the Executive Director for further recommendations and continue until the Quality Assurance team determines substantial compliance has been acheived.</p>	

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	<p>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 88 of 88 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 including residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of the Emergency Fire Watch with the Director of Plant Operations present on 07/09/14 at 12:30</p>	K010155	<ol style="list-style-type: none"> The fire watch policy and procedure now includes the phone numbers for the local fire department, insurance carrier, and the Indiana State Department of Health. This was completed by the Executive Director on 7/27/14. 88 of 88 residents had the potential to be affected by the deficient practice. All Emergency Preparedness Manuals were updated and redistributed to each nurse's station. All staff were re-educated on changes to manual regarding addition of phone numbers for the local fire department, insurance carrier and Indiana State Department of Health by the Executive Director on 7/23/14 and 7/24/14. The Executive Director will conduct an audit to ensure staff are able to locate an Emergency Preparedness binder three times a week for four weeks and then monthly for two months to verify ongoing compliance. Results of these audits will be presented by the Executive Director for further recommendations and continue until the Quality Assurance team determines substantial compliance has been achieved. 	08/08/2014			

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K020000	<p>p.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 phone numbers for the local fire department and the Indiana State Department of Health. The lack of this documentation was acknowledge by the Director of Plant Operations at the time of record review.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Dates: 07/09/14</p> <p>Facility Number: 002657 Provider Number: 155681 AIM Number: 200308930</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Autumn Woods Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42</p>	K020000		

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K020017 SS=E	<p>CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. The 400 and 500 Halls were surveyed with Chapter 18, New Health Care Occupancies.</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 hard wired smoke detectors in the corridors, in spaces open to the corridors, and in all resident sleeping rooms. The facility has a capacity of 93 and had a census of 88 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.</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 Corridor walls form a barrier to limit the transfer of smoke. Such walls are permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the</p>						

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	<p>corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 5 open use areas were separated from the corridor by walls constructed with at least a thirty minute fire resistance rating extending from the floor to the roof/floor above, or met an Exception. LSC 18-3.6.1, Exception # 1, Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas, and (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick response sprinklers, and (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space, and (d) The space does not obstruct access to required exits. This deficient practice could affect 9 residents, as well as staff and visitors in the 500 hall.</p> <p>Findings include:</p>	K020017	<ol style="list-style-type: none"> The 500 hall lounge is now protected by an electrically supervised automatic smoke detection system on 7/24/2014. 9 of 88 residents as well as staff and visitors had the potential to be affected by the deficient practice. All other areas in the campus have appropriate smoke detection systems. All smoke detection systems will be tested and documented quarterly by contracted vendor. Director of Plant operations will submit the report of testing the smoke detection systems to the Executive Director quarterly to verify ongoing compliance. Results of the testing of the smoke detection systems will be presented by DPO to the QA committee quarterly for review and further recommendations and will continue until the QA committee determines that substantial compliance has been achieved. 	08/08/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 07/09/2014
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NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150
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K020018 SS=B	<p>Based on observation on 07/09/14 at 1:20 p.m. during a tour of the facility with the Director of Plant Operations, the 500 hall lounge was open to the corridor. Exception #1, requirement (c) of LSC 18.3.6.1 was not met as follows: the 500 hall lounge was not protected by an electrically supervised automatic smoke detection system, or the entire space was not arranged and located to allow direct supervision by the facility staff from a nurses' stations or similar staffed space. This was acknowledged by the Director of Plant Operations at the time of observation.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 Based on observation and interview, the facility failed to ensure 2 of 2 sets of double doors to the corridors were equipped with positive latches and latched into the door frame. This deficient practice could affect up to 37 residents, as well as staff and visitors while in the 400 and 500 halls.</p>	K020018	<p>1. The 400 hall mechanical closet and 400 hall electrical closet are now equipped with positive latches and latched into the door frame on 7/31/2014. This was completed by the Director of Plant Operations. 2. 37 residents, staff and visitors on 400 and 500 hall had the potential to be affected by the deficient</p>	08/08/2014

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K020048 SS=C	<p>Findings include:</p> <p>Based on observations on 07/09/14 between 12:45 p.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations, the sets of double doors to the 400 hall Mechanical Closet and the 400 hall Electrical Closet did not automatically latch positively into their door frames, they had to be manually latched with a built in slide bolt latch located at the top edge of each door. This was acknowledged by the Director of Plant Operations at the time of observation.</p> <p>3.1-19(b)</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. 18.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 88 of 88 residents to accurately address all life safety systems such as the use of the K-class fire extinguisher in the kitchen thus addressing all items required</p>	K020048	<p>practice. A review of the campus found 100 hall mechanical room doors and (2) sets of doors in the east dining room with manual slide bolt latches. The identified doors were corrected on 7/31/2014 and are now equipped with positive latches and latched into the door frame. 3. The Director of Plant Operations was educated by the Executive Director on 7/29/2014 on the regulatory requirement of double doors to be equipped with positive latches. 4. The Director of Plant operations will conduct an audit of double doors ensuring the positive latches are in place and functioning properly one time weekly for four weeks and then monthly for two months. Results of these audits will be presented by the Director of Plant Operations to the QA committee for further recommendations and continue until the Quality Assurance team determines substantial compliance has been achieved.</p> <p>1. The "Fire" section of the Emergency Preparedness Manual now addresses the use of the K-class fire extinguisher in the kitchen on 7/27/2014. The Emergency Preparedness Manual now refers to "fire" without the use of the words</p>	08/08/2014			

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	<p>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 record review on 07/09/14 at 12:20 p.m. with the Director of Plant Operations present, the "Fire" section of the Emergency Preparedness Manual did not address the use of the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Furthermore, the use of the words "small", "major", and "minor" were used throughout the "Fire" section to describe the size of a fire. Based on interview at the time of record review, the Director of Plant Operations acknowledged the Fire plan did not address the use of the</p>		<p>small, major and minor to describe the size of the fire on 7/27/2014. 2. 88 of 88 residents had the potential to be affected by the deficient practice. 3. All Emergency Preparedness Manuals were updated and redistributed to each nurse's station on 7/27/14 by the Executive Director. All staff were educated on changes to manual regarding K-class fire extinguisher and removal of small, major and minor to describe the size of the fire. This was completed by the Executive Director. 4. The Executive Director will conduct an audit to ensure staff are able to locate an Emergency Preparedness binder three times a week for four weeks and then monthly for two months to verify ongoing compliance. Results of these audits will be presented by the Executive Director for further recommendations and continue until the Quality Assurance team determines substantial compliance has been achieved.</p>				

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K020050 SS=C	<p>K-class fire extinguisher in the kitchen, plus the use of the words small, major, and minor to describe the size of a fire.</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 audible alarms. 18.7.1.2 Based on record review and interview, the facility failed to ensure each documented fire drill included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department for 12 of 12 fire drills. LSC 18.7.1.2 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Trilogy Plant Operations Manual</p>	K020050	<p>1. The campus obtained documentation of the transmission of a fire signal to the monitoring company for 12 of 12 fire drills on 7/30/2014.</p> <p>2. 88 of 88 residents had the potential to be affected by the deficient practice.</p> <p>3. Director of Plant Operations was re educated on obtaining documentation of fire signal from monitoring company after each fire drill on 7/28/2014 by the Executive Director.</p> <p>4. Director of Plant Operations will submit the fire drill reports including</p>	08/08/2014

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K020154 SS=C	<p>on 07/09/14 at 11:40 a.m. with the Director of Plant Operations present, documentation for all twelve fire drills during the past twelve months did not include information indicating the monitoring company/fire department received the transmission of the fire alarm. Based on interview at the time of record review, the Director of Plant Operations acknowledged documentation for the fire drills did not include information the monitoring company/fire department received the transmission of the fire alarm.</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 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 complete written policy for the protection of 88 of 88 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>	K020154	<p>documentation of fire signal at monitoring company to the Executive Director monthly to verify ongoing compliance. Results of the fire drill reports will be presented by the DPO to the QA committee monthly for any recommendations and will continue until the QA committee determines that substantial compliance has been achieved.</p> <p>1. The fire watch policy and procedure now includes the phone numbers for the local fire department, insurance carrier and the Indiana State Department of Health. This was completed by the Executive Director on 7/27/14.</p>	08/08/2014

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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 residents, staff and visitors at the time of this survey.</p> <p>Findings include:</p> <p>Based on review of the Emergency Fire Watch with the Director of Plant Operations present on 07/09/14 at 12:30 p.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 phone numbers for the local fire department, insurance carrier, and the Indiana State Department of Health. The lack of this documentation was acknowledge by the Director of Plant Operations at the time of record review.</p> <p>3.1-19(b)</p>		<p>2. 88 of 88 residents had the potential to be affected by the deficient practice.</p> <p>3. All Emergency Preparedness Manuals were updated and redistributed to each nurse's station. All staff were re-educated on changes to manual regarding addition of phone numbers for the local fire department, insurance carrier and Indiana State Department of Health by the Executive Director on 7/23/14 and 7/24/14.</p> <p>4. The Executive Director will conduct an audit to ensure staff are able to locate an Emergency Preparedness binder three times a week for four weeks and then monthly for two months to verify on ongoing compliance. Results of these audits will be presented by the Executive Director for further recommendations and continue until the Quality Assurance team determines substantial compliance has been acheived.</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 88 of 88 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	<ol style="list-style-type: none"> 1. The fire watch policy and procedure now includes the phone numbers for the local fire department, insurance carrier, and the Indiana State Department of Health. This was completed by the Executive Director on 7/27/14. 2. 88 of 88 residents had the potential to be affected by the deficient practice. 3. All Emergency Preparedness Manuals were updated and redistributed to each nurse's station. All staff were re-educated on changes to manual regarding addition of phone numbers for the local fire department, insurance carrier and Indiana State Department of Health by the Executive Director on 7/23/14 and 7/24/14. 4. The Executive Director will conduct an audit to ensure staff are able to locate an Emergency Preparedness binder three times a week for four weeks and then 	08/08/2014

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	<p>including residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of the Emergency Fire Watch with the Director of Plant Operations present on 07/09/14 at 12:30 p.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 phone numbers for the local fire department and the Indiana State Department of Health. The lack of this documentation was acknowledge by the Director of Plant Operations at the time of record review.</p> <p>3.1-19(b)</p>		<p>monthly for two months to verify ongoing compliance. Results of these audits will be presented by the Executive Director for further recommendations and continue until the Quality Assurance team determines substantial compliance has been achieved.</p>	