

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155343	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/16/2011
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LAGRANGE	STREET ADDRESS, CITY, STATE, ZIP CODE 0770 N 075 E LAGRANGE, IN46761
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K0000	<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: 11/16/11</p> <p>Facility Number: 000235 Provider Number: 155343 AIM Number: 100267740</p> <p>Surveyor: Richard D. Schade, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Life Care Center of LaGrange 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>	K0000	The provider wishes this plan of correction be consideredour allegation of compliance. The following response and corrective actionstated within this 2567 plan of correction should not be considered as anadmission of guilt or wrong doing on the part of Life Care Center of LaGrange.The plan of correction is prepared and executed solely because it is requiredby the provision of Federal and State laws.	

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

TITLE

(X6) DATE

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

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	<p>This one story facility built in 1989 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, resident sleeping rooms and spaces open to the corridors. The facility has a capacity of 100 and had a census of 79 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/28/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0017 SS=E	Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 Based on observation and interview, the facility failed to ensure 2 of 2 offices with sliding glass windows were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b)	K0017	Corrective action accomplished for residents affected by the alleged deficient practice: The maintenance director installed a smoke detector in the reception office. How the facility will identify other residents potentially affected by the same deficient practice: The maintenance director or designee will conduct a weekly audit to ensure all common areas are protected by an electrically supervised automatic smoke detection system. What measures were put into place or systemic changes made to ensure that the alleged deficient practice does not recur: The maintenance director will add to his facility rounds checklist to ensure that all common areas are protected by an electrically supervised automatic smoke detection system. How corrective actions will be monitored to ensure the alleged deficient practice will not	12/16/2011

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	<p>Each space is protected by automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect any residents evacuated through the main entrance and northeast office on the 100 unit in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the maintenance supervisor on 11/16/11 at 12:45 p.m., the reception office at the main entrance and the northeast office had double sliding glass windows to the corridor. There was a one fourth inch gap between the two window panes. Exception # 6, requirement (a) of LSC Section 19-3.6.1 was not met in the office areas since they were not protected by an electrically supervised automatic smoke detection system. This was acknowledged by the maintenance supervisor at the time of observation.</p>		<p>recur: The maintenance director or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase/decrease the number of audits and frequency of audits.</p>		

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K0018 SS=E	<p>3.1-19(b)</p> <p>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 regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 1 sets of dining room doors on the 100 unit would not latch into the door frame or were provided with a device which exerts at least 5 pounds of pressure to keep the door tightly closed. This deficient practice could effect any occupants in and near the 100 unit including staff, visitors and residents.</p> <p>Findings include:</p>	K0018	<p>Corrective action accomplished for residents affected by the alleged deficient practice: The maintenance director adjusted the door to the 100 dining room (parlor) so that the doors latch into the door frame and remain secure. How the facility will identify other residents potentially affected by the same deficient practice: The maintenance director or designee will conduct a weekly audit to ensure all doors latch properly. What measures were put into place or systemic changes made to ensure that the alleged deficient practice does not recur: The maintenance director will add to his facility rounds checklist to ensure that all</p>	12/16/2011

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K0029 SS=E	<p>Based on observation on 11/16/11 at 1:10 p.m. with the maintenance supervisor, the pair of corridor doors to the dining room on 100 hall did not latch into the door frame and remain secure. The maintenance supervisor stated at the time of observation, he was not aware of the problem.</p> <p>3.1-19(b)</p> <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 at least 6 doors serving hazardous areas such as the 100 unit storage room and 200 central supply rooms closed and latched to</p>	K0029	<p>doors latch properly. How corrective actions will be monitored to ensure the alleged deficient practice will not recur: The maintenance director or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase/decrease the number of audits and frequency of audits.</p> <p>Corrective action accomplished for residents affected by the alleged deficient practice: The maintenance director installed door closers on the 100unit storage room and 200 hall central supply room. How the facility will identify other residents potentially affected by the same deficient</p>	12/16/2011	

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K0038 SS=E	<p>prevent the passage of smoke. This deficient practice could affect residents, visitors and staff in and near the hazardous rooms.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 11/16/11 between 12:15 p.m. and 1:40 p.m., the doors to the 100 unit storage room and the 200 central supply were not self closing, and did not latch securely into the door frame. The rooms had cardboard boxes and various plastic items stored in them. The maintenance supervisor acknowledged the problem areas at the time of observation.</p> <p>3.1-19(b)</p> <p>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</p>	K0038	<p>practice: The maintenance director or designee will conduct a weekly audit to ensure all doors shut and latch properly. What measures were put into place or systemic changes made to ensure that the alleged deficient practice does not recur: The maintenance director will add to his facility rounds checklist to ensure that all doors shut and latch properly. How corrective actions will be monitored to ensure the alleged deficient practice will not recur: The maintenance director or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase/decrease the number of audits and frequency of audits.</p> <p>Corrective action accomplished for residents affected by the</p>	12/16/2011	

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	<p>ensure 1 of 1 sets of exit access doors were arranged so the exit between the 100 and 200 halls was readily accessible at all times. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice effects all occupants on the including residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 11/16/11 at 12:10 p.m., exit doors between the 100 and 200 units are</p>		<p>alleged deficient practice: The maintenance director posted the security code to unlock the exit doors between 100 and 200 halls above the key pad. How the facility will identify other residents potentially affected by the same deficient practice: The maintenance director or designee will monitor weekly to ensure the security code to unlock the exit doors between 100 and 200 halls is posted. What measures were put into place or systemic changes made to ensure that the alleged deficient practice does not recur: The maintenance director will add to his facility rounds checklist to ensure that the security code to unlock the exit doors between 100 and 200 halls is posted above the key pad. How corrective actions will be monitored to ensure the alleged deficient practice will not recur: The maintenance director or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase/decrease the number of audits and frequency of audits.</p>		

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K0048 SS=F	<p>equipped with a magnetic door lock operated by the activation of the fire alarm system. The doors failed to release leaving the set of doors locked with no apparent or immediate method to release the doors. Based on observation there was no key pad or posted code to unlock the doors. The maintenance supervisor stated at the time of observation he was not aware of the problem.</p> <p>3.1-19(b)</p> <p>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 fire plan which includes the procedures for the use of all fire extinguishers for the protection 100 of 100 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan which shall provide policy and procedures for the following:</p>	K0048	<p>Corrective action accomplished for residents affected by the alleged deficient practice: The maintenance director added to the Emergency Procedure manual procedures for all the fire extinguishers and the relationship of the Class K extinguisher with the hood suppression system. How the facility will identify other residents potentially affected by the same deficient practice: The maintenance director will review the Emergency Procedure manuals throughout the facility to ensure the procedures for all the</p>	12/16/2011	

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	<p>(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> <p>This deficient practice could affect all occupants, visitors and staff in the facility in the event of an emergency when the written fire plan should be immediately available.</p> <p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 11/16/11 at 10:25 a.m., the written fire plan was found within the Emergency Procedure manual and the maintenance supervisor stated it was last reviewed August 2008. This Plan was the corporate policy which requires information specific</p>		<p>fire extinguishers and the relationship of the Class K extinguisher with the hood suppression system have been added to each manual. What measures were put into place or systemic changes made to ensure that the alleged deficient practice does not recur: The maintenance director will review the Emergency Procedure manual(s) monthly to ensure that any updates needed are added to the manual(s). How corrective actions will be monitored to ensure the alleged deficient practice will not recur: The maintenance director or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase/decrease the number of audits and frequency of audits.</p>				

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K0051 SS=F	<p>to the facility. The manual did not address the procedures for all of the fire extinguishers and the relationship of the Class K extinguisher with the hood suppression system. The maintenance supervisor stated, he was unaware of the requirement of the fire plan, extinguisher policy and procedure.</p> <p>3.1-19(b)</p> <p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and</p>	K0051	Corrective action accomplished for residents affected by the	12/16/2011	

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	<p>interview, the facility failed to provide 1 of 1 fire alarm systems with two means of transmitting a fire alarm to the monitoring station in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, 3-8.1 allows fire alarm system components to share control equipment or operate as standalone systems and they shall be arranged to function as a single system. NFPA 72, 5-5.3.2.1.6.1 requires a digital alarm communicator transmitter (DACT) shall be connected to two separate means of transmission at the protected premises. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 11/16/11 at 2:30 p.m., the automatic dialer component of the fire alarm system did not appear to have more than one phone line for communicating with the monitoring station. The maintenance</p>		<p>alleged deficient practice: The maintenance director had a second telephone line connected to the fire alarm system for communication with the monitoring station. How the facility will identify other residents potentially affected by the same deficient practice: The facility has only one fire alarm system. What measures were put into place or systemic changes made to ensure that the alleged deficient practice does not recur: The maintenance director will test the fire alarm system monthly to ensure that both phone lines are sending information to the monitoring station. How corrective actions will be monitored to ensure the alleged deficient practice will not recur: The maintenance director or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase/decrease the number of audits and frequency of audits.</p>		

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K0069 SS=E	<p>supervisor stated at the time of observation, they did not know if there were two phone lines. On 11/16/11 at 2:35 p.m., the maintenance supervisor called the fire alarm contractor and confirmed the fire alarm system was equipped with only a single phone line and no other means of automatically transmitting an alarm to the monitoring station.</p> <p>3.1-19(b)</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. LSC 19.3.2.6 requires cooking facilities to be in compliance with 9.2.3 which requires commercial cooking equipment to be in compliance with NFPA 96, the Standard for</p>	K0069	<p>Corrective action accomplished for residents affected by the alleged deficient practice: The maintenance director had a trained and qualified person clean and service the kitchen hood. How the facility will identify other residents potentially affected by the same deficient practice: The facility has contracted with Grease Busters to clean and service the kitchen hood twice annually. What measures were put into place or systemic changes made to ensure that the alleged deficient practice does</p>	12/16/2011

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	<p>Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, at 8-3.1 requires the cleaning of the hood every six months for systems serving moderate food volumes, by properly trained and qualified staff persons. This deficient practice could effect residents, staff and visitors in and near the kitchen area.</p> <p>Findings include:</p> <p>Based on record review of the documentation available for the kitchen hood cleaning at 11:15 a.m. on 11/16/11 with the maintenance supervisor, the kitchen hood had not been cleaned and serviced by trained and qualified personnel. The maintenance supervisor stated at the time of observation, he had no training or qualifications to clean the facility's kitchen hood.</p> <p>3.1-19(b)</p>		<p>not recur: The maintenance director will ensure that the kitchen hood is serviced by a trained and qualified person twice annually and retain the documentation of the service. How corrective actions will be monitored to ensure the alleged deficient practice will not recur: The maintenance director or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase/decrease the number of audits and frequency of audits.</p>		

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K0154 SS=F	<p>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 containing procedures to be followed, to protect 100 of 100 residents, 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 to 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 to be notified.</p> <p>This deficient practice could affect</p>	K0154	<p>Corrective action accomplished for residents affected by the alleged deficient practice: The maintenance director added the verbiage, "within a 24hour period" to the existing fire watch procedure so that the procedure reads:In the event that the facility fire alarm system and/or facility sprinkler system are down for more than 4 hours within a 24 hour period, it is necessary for the facility to conduct a fire watch every 15 minutes and document the results. How the facility will identify other residents potentially affected by the same deficient practice: The maintenance director will review the Emergency Procedure manuals throughout the facility to ensure the procedures for fire watch have been updated in each manual. What measures were put into place or systemic changes made to ensure that the alleged deficient practice does not recur: The maintenance director will review the Emergency Procedure manual(s) monthly to ensure that any updates needed are added to the manual(s). How corrective actions will be monitored to</p>	12/16/2011
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	<p>all occupants in the facility including residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's policy and procedure book with the maintenance supervisor on 11/16/11 at 10:40 a.m., the fire watch procedure for an out of service automatic sprinkler system was incomplete. The procedure lacked that the fire watch would be implemented if the system were down for more than four hours in a 24 hour period. The interview with the maintenance supervisor at the time of the record review indicated no other policy or procedure was available to review. The maintenance supervisor stated he was unaware of the requirement.</p> <p>3.1-19(b)</p>		<p>ensure the alleged deficient practice will not recur: The maintenance director or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase/decrease the number of audits and frequency of audits.</p>		

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K0155 SS=F	<p>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 containing 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 to protect 100 of 100 residents, 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</p>	K0155	<p>Corrective action accomplished for residents affected by the alleged deficient practice: The maintenance director added the verbiage, "within a 24hour period" to the existing fire watch procedure so that the procedure reads:In the event that the facility fire alarm system and/or facility sprinkler system are down for more than 4 hours within a 24 hour period, it is necessary for the facility to conduct a fire watch every 15 minutes and document the results. How the facility will identify other residents potentially affected by the same deficient practice: The maintenance director will review the Emergency Procedure manuals throughout the facility to ensure the procedures for fire watch have been updated in each manual. What measures were put into place or systemic changes made to ensure that the alleged deficient practice does not recur: The maintenance director will review the Emergency Procedure manual(s) monthly to ensure that any updates needed are added to the manual(s). How corrective actions will be monitored to ensure the alleged deficient</p>	12/16/2011

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	<p>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 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's policy and procedure book with the maintenance supervisor on 11/16/11 at 10:40 a.m., the fire watch procedure for an out of service automatic fire alarm system system was incomplete. The procedure lacked that the fire watch would be implemented if the system were down for more than four hours in a 24 hour period. The interview with the maintenance supervisor at the time of the record review indicated no other policy or procedure was available to review. The maintenance supervisor stated he was unaware of the requirement.</p>		<p>practice will not recur: The maintenance director or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase/decrease the number of audits and frequency of audits.</p>		

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K0211 SS=E	<p>3.1-19(b)</p> <p>Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>Based on observation and interview, the facility failed to ensure 2 of 2 alcohol hand sanitizing dispensers in the transition dining room were not installed above electrical switches which may arc during normal use. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency. This deficient practice could affect all residents, staff and visitors in or near the</p>	K0211	<p>Corrective action accomplished for residents affected by the alleged deficient practice: The maintenance director moved the two alcohol hand sanitizing dispensers so that they were not mounted above the electrical switches How the facility will identify other residents potentially affected by the same deficient practice: The maintenance director conducted a 100% audit of alcohol hand sanitizing dispensers in the facility to ensure that none are installed over or adjacent to an ignition source. What measures were put into place or systemic changes made to ensure that the alleged deficient practice does not recur:</p>	12/16/2011

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	<p>transition dining room.</p> <p>Findings include:</p> <p>Based on observation of the transition dining room on 11/16/11 at 2:40 p.m. with the maintenance supervisor, the two hand sanitizing dispensers were mounted within six inches above electrical switches. There was evidence of splashing below the dispensers on the wall. The maintenance supervisor acknowledged at the time of the observation, the hand sanitizers should be moved.</p> <p>3.1-19(b)</p>		<p>The maintenance director will add to his facility rounds checklist to ensure that all alcohol hand sanitizing dispensers in the facility are not installed over or adjacent to an ignition source. How corrective actions will be monitored to ensure the alleged deficient practice will not recur: The maintenance director or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase/decrease the number of audits and frequency of audits.</p>		