

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2013
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NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122
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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: 06/20/13</p> <p>Facility Number: 000057 Provider Number: 155132 AIM Number: 100266570</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Danville Regional Rehabilitation 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. Building 0102 built prior to March 1, 2003 was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building 0102 built prior to March 1, 2003 was determined to be of Type V (111) construction and was fully</p>	K010000	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."</p>	
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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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	<p>sprinklered except for three exterior canopies for the Active Life Transition Unit building. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system for resident sleeping rooms in the Active Life Transition Unit and has battery operated smoke detectors installed in all other resident sleeping rooms. The facility has a capacity of 127 and had a census of 84 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered except for three exterior canopies for the Active Life Transition Unit building. The facility has two detached buildings providing facility services which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/27/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010017 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 open use areas was separated from the corridor, or met an Exception. LSC 19.3.6.1, 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. (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 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke</p>	K010017	<p>This facility does ensure that areas open to corridors without supervision from the nurses station are equipped with with automatic smoke detection. The reception area has been equipped with a smoke detector, and the window separating the area from corridor has been removed. No residents have been effected by this alleged deficiency. Smoke detectors will be checked monthly for appropriate working order and the location of those found not working properly will be repaired or replaced immediately. Results of the smoke detector checks will be compiled and presented monthly QA&A Committee for a period of six months, with action taken as needed.ADDENDUM: Hard wired smoke detector is being installed in the reception</p>	07/20/2013			

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	<p>detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect 26 residents adjacent to the Front Reception office by the front entrance as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Manager during a tour of the facility from 1:35 p.m. to 4:30 p.m. on 06/20/13, the Reception office next to the Main Entrance had sliding glass windows separating the office from the corridor and it was open to the corridor at the time of observation. Furthermore, there was a one eighth inch open space between the glass panes as they slide horizontally along its metal track. Exception # 1, requirement (c) of the Life Safety Code, Chapter 19.3.6.1 was not met as follows: the open area was not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. Based on interview at the time of observation, the Maintenance Manager acknowledged acknowledged the Reception office which</p>		<p>area on Tuesday July 23rd by Vanguard. This will allow the smoke detector to alarm at the enunciation panel and automatically contact monitoring company and emergency services when activated.</p>				

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	<p>was open to the corridor without supervision from the nurse's station and was not protected by automatic smoke detection.</p> <p>3.1-19(b)</p>			

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K010018 SS=E	<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 1¾ 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 over 100 corridor doors resisted the passage of smoke. This deficient practice could affect 12 residents, staff and visitors in the vicinity of the Break Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Manager during a tour of the facility from 1:35 p.m. to 4:30 p.m. on 06/20/13, the corridor door to the Break Room had a three quarter inch in diameter hole in the door above the door handle which was not smoke resistant. Based on interview at the time of observation, the Maintenance Manager acknowledged the aforementioned corridor door was not</p>	K010018	This facility does ensure that all corridor doors resist the passage of smoke. The three quarter inch diameter hole in the door above the door handle has been covered making it smoke resistant. This did not effect any residents. All corridor doors have been inspected to ensure there are no other issues related to the passage of smoke. Facility will continue to inspect all corridor doors for damage monthly for a period of six months reporting findings to QA&A Committee for any identified trends or required actions.	07/20/2013			

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	smoke resistant. 3.1-19(b)			

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K010021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 doors to hazardous areas such as the kitchen was held open only by devices which allow the door to automatically close, or close upon activation of the fire alarm system. This deficient practice could affect 25 residents, staff and visitors in the Long Term Care Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Manager during a tour of the facility from 1:35 p.m. to 4:30 p.m. on 06/20/13, a kick down door stop attached to the kitchen entry door from the Long Term Dining Room was in use to prop the door to this hazardous area open. Based on interview at the time of observation,</p>	K010021	<p>This facility does ensure that doors to all hazardous areas are held open only by devices which allow the door to automatically close, or upon activation of the fire alarm system. The door stop attached to the door from the kitchen to the long term care dining room has been removed and all dining service personell have been inserviced on expectations related to doors. This alleged practice did not effect any residents. Maintenance Director and or designee will continue to monitor all doors monthly for proper functioning / compliance reporting all findings to QA&A committee monthly for six months.</p>	07/20/2013
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	the Maintenance Manager acknowledged the door to the kitchen from the Long Term Care Dining Room was propped fully open with a kick down door stop. 3.1-19(b)			

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K010025 SS=E	<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>Based on observation and interview, the facility failed to ensure ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 24 residents, staff and visitors in the vicinity of the HVAC Mechanical Room near the Main Entrance.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Manager during a tour of the facility from 1:35 p.m. to 4:30 p.m. on 06/20/13, the two inch annular space surrounding twenty cables passing through the ceiling into the attic in the HVAC Mechanical Room near the Main Entrance was not firestopped. The two inch opening did not maintain the one half hour fire resistance rating of the smoke barrier. Based on interview at the time of observation, the Maintenance</p>	K010025	<p>This facility does ensure that ceiling smoke barriers are maintained to provide at least a one half hour fire resistance rating. The two inch annular space surrounding twenty cables passing through the ceiling into the attic in the HVAC Mechanical Room near the main entrance has been firestopped. This practice did not effect any residents. A full inspection of the building has been completed to ensure compliance. Maintenance Director or designee will inspect smoke barriers monthly to ensure compliance, reporting to QA&A Committee any issues or trends for a period of six months.</p>	07/20/2013			

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	<p>Manager acknowledged the aforementioned opening in the ceiling smoke barrier in the HVAC Mechanical Room near the Main Entrance was not firestopped.</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 1 of 2 doors to hazardous areas such as the kitchen closed automatically, or upon activation of the fire alarm system, and latched into the door frame. This deficient practice could affect 25 residents, staff and visitors in the Long Term Care Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Manager during a tour of the facility from 1:35 p.m. to 4:30 p.m. on 06/20/13, a kick down door stop attached to the kitchen entry door from the Long Term Dining Room was in use to prop the door to this hazardous area open. Based on interview at the time of observation, the Maintenance Manager acknowledged the door to the kitchen from the Long Term Care Dining Room was propped</p>	K010029	<p>This facility does ensure that doors to all hazardous areas are held open only by devices which allow the door to automatically close, or upon activation of the fire alarm system. The door stop attached to the door from the kitchen to the long term care dining room has been removed and all dining service personell have been inserviced on expectations related to doors. This alleged practice did not effect any residents. Maintenance Director and or designee will continue to monitor all doors monthly for proper functioning / compliance reporting all findings to QA&A committee monthly for six months.</p>	07/20/2013			

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	fully open with a kick down door stop. 3.1-19(b)				

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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 provide 2 of over 100 corridor room doors with not more than one releasing operation. LSC Section 7.2.1.5.4 states a latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches above the finished floor. Doors shall be operable with not more than one releasing operation. Section A.7.2.1.5.4 states examples of devices that might be arranged to release latches include knobs, levers, and panic bars. This deficient practice could affect six staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Manager during a tour of the facility from 1:35 p.m. to 4:30 p.m. on 06/20/13, the following was noted:</p> <p>a. the corridor door to the kitchen has two locks on the door and a key was needed to unlock each lock on the door.</p> <p>b. the corridor door to the Mechanical</p>	K010038	<p>This facility does ensure that all corridor doors have no more than one releasing operation. A. The door to the kitchen has had one lock removed. B. The corridor to the mechanical room by the laundry has had one lock removed. No residents or visitors were affected by this practice. All corridor doors have been inspected to ensure proper functioning / compliance. Maintenance Director or designee will inspect all doors monthly to ensure there are no more than one releasing operation, those not in compliance will be repaired immediately. Results of inspection will be reported to QA&A Committee for a period of six months with actions taken as recommended.</p>	07/20/2013			

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	<p>room by the laundry has two locks on the door and a key was needed to unlock each lock on the door.</p> <p>Based on interview at the time of the observations, the Maintenance Manager acknowledged the aforementioned corridor doors each required more than one releasing operation to open the door.</p> <p>3-1.19(b)</p>				

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K010046 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 20 of 20 battery powered lights for 12 months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hr duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Lights Battery Check Annually 90 Minutes", Vanguard Alarm Services "Emergency Light Inspection Record" dated 02/26/13 and the associated Vanguard invoice dated 05/20/13 with the Maintenance Manager during record review from 9:20 a.m. to 12:20 p.m. on 06/20/13, the</p>	K010046	<p>This facility does document testing of emergency lighting with written records of visual inspections and tests and does make those records available to the authority having jurisdiction. The annual ninety minute test for each of twenty battery operated emergency lights in the facility for the most recent twelve month period has been located and is available to the authority having jurisdiction, additionally functional testing documentation at 30 day intervals for not less than 30 seconds for each of twenty battery powered emergency lights in the facility for the most recent twelve month period is now available for review. There were no residents affected, Maintenance Director or designee will continue testing and ensure validation of testing is available to authority having jurisdiction reporting to QA&A Committee any issues with testing or reporting process. QA&A Committee to review for a period of no less than six months with recommendations as needed.</p>	07/20/2013			

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	<p>following was noted:</p> <p>a. documentation of an annual ninety minute test for each of twenty battery operated emergency lights in the facility for the most recent twelve month period was not available for review. Vanguard Alarm Services "Emergency Light Inspection Record" dated 02/26/13 did not indicate the inspection record was for an annual ninety minute test. In addition, the associated invoice from Vanguard dated 05/20/13 stated "Emergency Light Inspection to be conducted in February" which did not state an annual ninety minute test was performed.</p> <p>b. functional testing documentation at 30 day intervals for not less than 30 seconds for each of twenty battery powered emergency lights in the facility for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Manager stated "Emergency Lights Battery Check Annually 90 Minutes" documentation is a monthly record of functional testing for less than thirty seconds and is not a record of annual ninety minute testing and acknowledged documentation of an annual ninety minute test for each of twenty battery operated emergency lights in the facility for the most recent twelve month period was not available for review. In addition, the Maintenance</p>				

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	<p>Manager stated monthly functional testing as documented in "Emergency Lights Battery Check Annually 90 Minutes" is not a minimum 30 second test for each light and acknowledged functional testing documentation at 30 day intervals for not less than 30 seconds for each of twenty battery powered emergency lights in the facility for the most recent twelve month period was not available for review. Based on observations with the Maintenance Manager during a tour of the facility from 1:35 p.m. to 4:30 p.m. on 06/20/13, twenty battery powered emergency lights were observed in the facility.</p> <p>3.1-19(b)</p>			

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K010048 SS=E	<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</p> <p>1. Based on record review, observation and interview; the facility failed to develop a written fire safety plan for staff response to the activation of battery operated smoke detectors installed in 39 of 77 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <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 78 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Preparedness Manual - Fire Safety Plans" documentation with the Maintenance Manager during record review from 9:20 a.m. to 12:20 p.m. on 06/20/13, the facility's written fire safety plan did not</p>	K010048	<p>K48- This facility has developed a written safety plan for staff response to the activation of battery operated smoke detectors and the use of ABC and K Class Fire Extinguishers when used in kitchen with overhead extinguishing system. Facilities current fire safety plan has been updated to include the activation of battery operated smoke detectors and staff response as well as the use of ABC and K Class Fire Extinguishers used in the kitchen which is equipped with an overhead extinguishing system. Copies of updated fire safety plan have been placed in all Emergency Preparedness Manuals and in-service education has been provided to dietary personell. No residents have been affected by this practice. Maintenance Director or designee will conduct periodic drills related to smoke detector activation and extinguisher use providing results of drills to QA&A Committee for a period of six months in order to identify concerns or education needs.</p>	07/20/2013

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	<p>include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms. Based on observations with the Maintenance Manager during a tour of the facility from 1:35 p.m. to 4:30 p.m. on 06/20/13, battery operated smoke detectors were installed in 39 of 77 resident sleeping rooms. Based on interview at the time of record review, the Maintenance Manager acknowledged the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in 39 resident sleeping rooms.</p> <p>3.1-19(a)</p> <p>2. Based on record review, observation and interview; the facility failed to include the use of kitchen fire extinguishers in the written fire safety plan for the facility in the event of an emergency. LSC 19.2.2.2 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 			

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	<p>evacuation (8) Extinguishment of fire This deficient practice affects staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on review of "Emergency Preparedness Manual - Fire Safety Plans" documentation with the Maintenance Manager during record review from 9:20 a.m. to 12:20 p.m. on 06/20/13, the fire disaster plan did not address the use of the ABC type fire extinguishers and the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on observations with the Maintenance Manager during a tour of the facility from 1:35 p.m. to 4:30 p.m. on 06/20/13, an ABC type and a K-class fire extinguisher was located in the kitchen. Based on interview at the time of record review, the Maintenance Manager acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K-class fire extinguisher.</p> <p>3.1-19(b)</p>				

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K010050 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 4 of 4 quarters. This deficient practice affects all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Maintenance Manager during record review from 9:20 a.m. to 12:20 p.m. on 06/20/13, third shift fire drills conducted on 08/29/12, 10/19/12, 11/29/12, 12/31/12, 01/30/13, 02/28/13, 03/27/13, 04/24/13 and 05/28/13 were conducted, respectively, at 4:16 a.m., 4:15 a.m., 4:51 a.m., 5:10 a.m., 4:59 a.m., 4:40 a.m., 4:48 a.m., 4:59 a.m. and 4:50 a.m. Based on interview at the time of record review, the Maintenance Manager acknowledged third shift fire</p>	K010050	K050-This facility does ensure that fire drills are held at unexpected times under varying conditions, and at least quarterly on each shift. Maintenance Director has been educated and understands importance of conducting drills at various times. All fire drills occurring on third shift will be scheduled in advance with administrator to ensure compliance. No residents have been effected, Administrator to review times and conditions of all completed fire drills for a period of six months reporting compliance issues to QA&A Committee for review and recommendation.	07/20/2013			

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	<p>drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p>			

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K010052 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on observation and interview, the facility failed to maintain 2 of 114 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect 24 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Manager during a tour of the facility from 1:35 p.m. to 4:30 p.m. on 06/20/13, the smoke detectors on the ceiling in the corridor outside Room 405 and outside Room 505 were each located two feet from an air supply vent. Based on interview at the time of the observations, the Maintenance Manager acknowledged the aforementioned smoke detector locations were each installed less</p>	K010052	<p>K052-This facility maintains all smoke detectors in accordance with NFPA 72 by ensuring that all smoke detectors are no closer than three feet from an air supply diffuser or return air opening. The smoke detectors on the ceiling in the corridor outside rooms 405 and 505 have been moved to ensure compliance. There were no residents effected by this alleged deficiency. Maintenance Director or designee to complete inspection of all smoke detectors to ensure compliance reporting findings to QA&A Committee for a period of six months for review and recommendation.</p>	07/20/2013
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	than three feet from an air supply vent. 3.1-19(b)				

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 5-6.5 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-6.5.2 and 5-6.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could affect 60 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Manager during a tour of the facility from 1:35 p.m. to 4:30 p.m. on</p>	K010056	This facility does ensure that the sprinkler system currently installed does meet the requirements established of NFPA 13. The pendant sprinkler in the HVAC Mechanical Closet near the main entrance has been moved to minimize any obstruction. The horizontal shelf in the Water Softener Closet in the Long Term Care Dining Room has been removed in order not to obstruct the sprinkler pendant. An additional pendant has been added in the laundry area behind the dryers in order to ensure coverage of the entire room. Facility has also added sprinkler pendants to the exterior canopies at the Active Life Transitions Unit exit by room 408 and 509. Sprinkler Pendant was also added to exterior canopy at the north entrance to building. No residents were effected by this	07/20/2013

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	<p>06/20/13, the following was noted:</p> <p>a. the HVAC Mechanical Room near the Main Entrance was provided with one pendant sprinkler head installed on the ceiling and an air return plenum in the room obstructed the sprinkler coverage for half the room.</p> <p>b. the Water Softener Closet in the Long Term Care Dining Room contained two water softeners which were covered by a horizontal shelf obstructing the discharge pattern of the one pendant sprinkler head installed on the closet ceiling.</p> <p>c. one pendant sprinkler head was installed on the ceiling behind the dryers in the Laundry Room and a three foot in diameter dryer vent obstructed sprinkler coverage for half the room.</p> <p>Based on interview at the time of the observations, the Maintenance Manager acknowledged the aforementioned pendant sprinkler head locations had obstructions to the discharge pattern which did not ensure complete sprinkler coverage.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>2. Based on observation and interview, the facility failed to provide sprinkler coverage for 3 of 4 combustible exterior canopies wider than 4 feet. NFPA 13, 1999 Edition, Section 5-13.8.1 requires</p>		<p>alleged deficiency. Maintenance director to complete inspection of building to ensure no canopied areas of building are in need of sprinkler pendants and that those sprinkler pendants currently in use are not obstructed. Maintenance Director or designee will complete monthly inspection of building for a period of six months ensuring that all canopied areas are in compliance and that there are no obstructions to the currently installed sprinkler pendants. Reports of inspections will be presented to the monthly QA&A Committee for review and necessary action.</p>				

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	<p>sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect 24 residents, staff and visitors if needing to exit the Active Life Transition Unit building.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Manager during a tour of the facility from 1:35 p.m. to 4:30 p.m. on 06/20/13, the following was noted:</p> <p>a. the exterior canopies at the Active Life Transition Unit exit by Room 408 and by Room 509 each extended 54 inches (4 feet, 6 inches) from the building, were of wood and were not provided with automatic sprinklers.</p> <p>b. the exterior awning at the North Entrance to the Active Life Transition Unit extended ten feet from the building, was of metal and fabric construction and was not provided with automatic sprinklers.</p> <p>Based on interview at the time of observation, the Maintenance Manager stated fire resistance rating documentation for the fabric utilized in the exterior awning at the North Entrance to the Active Life Transition Unit was not available for review and acknowledged each of the three aforementioned canopies extended more than four feet from the</p>			

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	building, was of combustible construction and was not provided with automatic sprinklers. 3.1-19(b) 3.1-19(ff)				

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K010062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace 1 of over 100 sprinklers in the facility. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 24 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Manager during a tour of the facility from 1:35 p.m. to 4:30 p.m. on 06/20/13, the automatic sprinkler located behind the dryers in the Laundry Room was covered with laundry lint. Based on interview at the time of observation, the Maintenance Manager acknowledged the aforementioned automatic sprinkler location was covered with laundry lint.</p>	K010062	<p>This facility does ensure that sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. The automatic sprinkler pendant located in the laundry room behind the dryer has been cleaned in order to ensure no obstruction will interfere with the flow. No residents were affected by this alleged deficiency. Housekeeping Supervisor or designee to clean and inspect all sprinkler heads weekly for a period of six months reporting to administrator any pendant needing to be replaced. Results of inspections will be reported to the QA&A Committee for review and recommendations.</p>	07/20/2013			

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	3.1-19(b)			

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K010064 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to inspect 1 of 17 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect 24 residents, staff and visitors in the vicinity of the Beauty Shop.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Manager during a tour of the facility from 1:35 p.m. to 4:30 p.m. on 06/20/13, the annual maintenance tag attached to the portable fire extinguisher located in the Beauty Shop indicated a</p>	K010064	<p>This facility does ensure that fire extinguishers are provided and inspected on a monthly basis. Fire Extinguisher in the beauty shop has been inspected to ensure it is available and will operate. No residents have been affected by this alleged deficiency. Beauty shop extinguisher as well as all other extinguishers will be inspected monthly and results of inspection will be put on master extinguisher checklist to be reviewed by administrator monthly. Administrator to present master checklist to QA&A Committee for review and recommendation for a period of no less than six months.</p>	07/20/2013			

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	<p>monthly inspection was not documented for March, April and May 2013. Based on interview at the time of observation, the Maintenance Manager stated no other monthly fire extinguisher inspection documentation was available for review and acknowledged a monthly inspection for the portable fire extinguisher located in the Beauty Shop was not documented for March, April and May 2013.</p> <p>3.1-19(b)</p>			

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K010067 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on record review and interview, the facility failed to ensure 101 of 101 fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Mowery Heating-Air Conditioning-Plumbing "Fire Damper Inspection" documentation dated 08/08/12 during record review with the Maintenance Manager from 9:20 a.m. to</p>	K010067	<p>This facility does ensure that heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. Local heating-air conditioning-plumbing company who provided the 8/8/2012 inspection has been contacted to provide facility with itemized listing of fire damper locations and the results of testing conducted on above date. This information will be made available to the authority having jurisdiction upon request. There were no residents affected by this alleged deficiency. Facility will continue with fire damper testing as per regulation, results of testing will be provided to the QA&A committee monthly for six months and then annually for review and recommendation.</p>	07/20/2013			

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	<p>12:20 p.m. on 06/20/13, documentation of an itemized listing of fire damper location and the results of the test was not available for review. The Mowery "Fire Damper Inspection" documentation stated "located and serviced 101 fire dampers" and "replaced fusible links on ones that were missing or not operating." Based on interview at the time of record review, the Maintenance Manager stated there are fire dampers located throughout the facility and no documentation of testing date information is placed at the fire damper locations and acknowledged an itemized listing of fire damper locations and the results of testing was not available for review.</p> <p>3.1-19(b)</p>			

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K010130 SS=C	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to ensure 6 of 7 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Certificate of Inspection" from the State of Indiana and CNA Insurance Company "Boiler-Fired Pressure Vessel Report of Inspection" documentation dated 09/26/11 with the Maintenance Manager during record review from 9:20 a.m. to 12:20 p.m. on 06/20/13, the following natural gas fired water heaters had expired or missing Certificate of Inspection documentation from the State of Indiana:</p> <p>a. the service water heaters identified as IN251960 and IN292223 each had a Certificate of Inspection expiration date of 09/14/11.</p> <p>b. the service water heaters identified as IN311699, IN311668 and IN282284 had</p>	K010130	<p>This facility does ensure that fired water heaters have current inspection certificates to ensure water heaters are in safe operating condition. Inspection of all water heaters occurred on 7/8/2013 and appropriate paperwork sent to authority having jurisdiction for certificate disbursement. All water heaters have had certificates of inspection placed next to them. No residents have been affected by alleged deficiency. Maintenance Director or designee to inspect all water heaters monthly for a period of six months to ensure all inspection certificates are current and located next to them. Results of inspections will be presented to QA&A Committee for a review and recommendation.</p>	07/20/2013			

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	<p>missing Certificate of Inspection documentation.</p> <p>c. the service water heater located in the Maintenance Office had no identification number from the State of Indiana and had missing Certificate of Inspection documentation.</p> <p>Based on observations with the Maintenance Manager during a tour of the facility from 1:35 p.m. to 4:30 p.m. on 06/20/13, updated Certificate of Inspection documentation from the State of Indiana was not located at each of the six aforementioned service water heater locations. Based on interview at the time of record review, the Maintenance Manager acknowledged the aforementioned natural gas fired water heaters had expired or missing Certificate of Inspection documentation from the State of Indiana.</p> <p>3.1-19(b)</p>			

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K010154 SS=C	<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 containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1 in order to protect 84 of 84 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the 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 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.</p> <p>Findings include:</p>	K010154	This facility does provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a twenty four hour period. The Emergency Preparedness Manual-Code Red Policy has been updated to include that the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected should the automatic sprinkler system be impaired for four hours or more in a twenty four hour period. Additionally the policy has been updated to include specific notification of the ISDH, Insurance Carrier and bulding owner/manage should the above occur. No residents, employee's or visitors were affected by this alleged deficiency. All staff have been inserviced on updated policy. Maintenance Director or designee will audit all emergency preparedness binders for a period of no less than six months to ensure policy is intact and	07/20/2013			

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	<p>Based on review of "Emergency Preparedness Manual - Code Red" documentation with the Maintenance Manager during record review from 9:20 a.m. to 12:20 p.m. on 06/20/13, the following was noted:</p> <p>a. the fire watch policy did not include the statement the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected should the automatic sprinkler system be impaired for four hours or more in twenty four hour period.</p> <p>b. the fire watch policy did not include notification of the Indiana State Department of Health, which is the authority having jurisdiction, and did not include notification of the insurance carrier, alarm company and the building owner/manager.</p> <p>Based on interview at the time of record review, the Maintenance Manager stated no additional fire watch documentation was available for review and acknowledged the written fire watch policy did not include the aforementioned statement and notification of the aforementioned entities.</p> <p>3.1-19(b)</p>		accurate. Findings to be reported to QA&A committee for review and recommendation.		

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K010155 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 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 in accordance with LSC, Section 9.6.1.8 in order to protect 84 of 84 residents. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Preparedness Manual - Code Red" documentation with the Maintenance Manager during record review from 9:20 a.m. to 12:20 p.m. on 06/20/13, the following was noted:</p> <p>a. the fire watch policy did not include the statement the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected should the fire alarm system be impaired for four hours or more in twenty four hour period.</p>	K010155	This facility does 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 twenty four hour period. The Emergency Preparedness Manual-Code Red Policy has been updated to include that the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected should the Fire Alarm System be impaired for four hours or more in a twenty four hour period. Additionally the policy has been updated to include specific notification of the ISDH, Insurance Carrier and bulding owner/manage should the above occur. No residents, employee's or visitors were affected by this alleged deficiency. All staff have been inserviced on updated policy. Maintenance Director or designee will audit all emergency preparedness binders for a period of no less than six months to ensure policy is intact and accurate. Findings to be reported to QA&A committee for review	07/20/2013			

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	<p>b. the fire watch policy did not include notification of the Indiana State Department of Health, which is the authority having jurisdiction. Based on interview at the time of record review, the Maintenance Manager stated no additional fire watch documentation was available for review and acknowledged the written fire watch policy did not include the aforementioned statements.</p> <p>3.1-19(b)</p>		and recommendation.	

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K020000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/20/13</p> <p>Facility Number: 000057 Provider Number: 155132 AIM Number: 100266570</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Danville Regional Rehabilitation 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. Building 0202 built in 2010 was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building 0202 consists of the walkway addition, was built after March 1, 2003, was determined to be of Type V</p>			K020000	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."</p>		

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	<p>(111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system for resident sleeping rooms in the Active Life Transition Unit and has battery operated smoke detectors installed in all other resident sleeping rooms. The facility has a capacity of 127 and had a census of 84 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered except for three exterior canopies for the Active Life Transition Unit building. The facility has two detached buildings providing facility services which were not sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K020050 SS=C	<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</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 4 of 4 quarters. This deficient practice affects all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Maintenance Manager during record review from 9:20 a.m. to 12:20 p.m. on 06/20/13, third shift fire drills conducted on 08/29/12, 10/19/12, 11/29/12, 12/31/12, 01/30/13, 02/28/13, 03/27/13, 04/24/13 and 05/28/13 were conducted, respectively, at 4:16 a.m., 4:15 a.m., 4:51 a.m., 5:10 a.m., 4:59 a.m., 4:40 a.m., 4:48 a.m., 4:59 a.m. and 4:50 a.m. Based on interview at the time of record review, the Maintenance Manager acknowledged third shift fire</p>	K020050	K050-This facility does ensure that fire drills are held at unexpected times under varying conditions, and at least quarterly on each shift. Maintenance Director has been educated and understands importance of conducting drills at various times. All fire drills occurring on third shift will be scheduled in advance with administrator to ensure compliance. No residents have been effected, Administrator to review times and conditions of all completed fire drills for a period of six months reporting compliance issues to QA&A Committee for review and recommendation.	07/20/2013			

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NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122
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	<p>drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p>			

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K020154 SS=C	<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 containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1 in order to protect 84 of 84 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the 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 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.</p> <p>Findings include:</p>	K020154	This facility does provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a twenty four hour period. The Emergency Preparedness Manual-Code Red Policy has been updated to include that the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected should the automatic sprinkler system be impaired for four hours or more in a twenty four hour period. Additionally the policy has been updated to include specific notification of the ISDH, Insurance Carrier and bulding owner/manage should the above occur. No residents, employee's or visitors were affected by this alleged deficiency. All staff have been inserviced on updated policy. Maintenance Director or designee will audit all emergency preparedness binders for a period of no less than six months to ensure policy is intact and	07/20/2013			

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	<p>Based on review of "Emergency Preparedness Manual - Code Red" documentation with the Maintenance Manager during record review from 9:20 a.m. to 12:20 p.m. on 06/20/13, the following was noted:</p> <p>a. the fire watch policy did not include the statement the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected should the automatic sprinkler system be impaired for four hours or more in twenty four hour period.</p> <p>b. the fire watch policy did not include notification of the Indiana State Department of Health, which is the authority having jurisdiction, and did not include notification of the insurance carrier, alarm company and the building owner/manager.</p> <p>Based on interview at the time of record review, the Maintenance Manager stated no additional fire watch documentation was available for review and acknowledged the written fire watch policy did not include the aforementioned statement and notification of the aforementioned entities.</p> <p>3.1-19(b)</p>		accurate. Findings to be reported to QA&A committee for review and recommendation.		

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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 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 in accordance with LSC, Section 9.6.1.8 in order to protect 84 of 84 residents. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Preparedness Manual - Code Red" documentation with the Maintenance Manager during record review from 9:20 a.m. to 12:20 p.m. on 06/20/13, the following was noted:</p> <p>a. the fire watch policy did not include the statement the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected should the fire alarm system be impaired for four hours or more in twenty four hour period.</p>	K020155	This facility does 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 twenty four hour period. The Emergency Preparedness Manual-Code Red Policy has been updated to include that the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected should the Fire Alarm System be impaired for four hours or more in a twenty four hour period. Additionally the policy has been updated to include specific notification of the ISDH, Insurance Carrier and bulding owner/manage should the above occur. No residents, employee's or visitors were affected by this alleged deficiency. All staff have been inserviced on updated policy. Maintenance Director or designee will audit all emergency preparedness binders for a period of no less than six months to ensure policy is intact and accurate. Findings to be reported to QA&A committee for review	07/20/2013			

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	<p>b. the fire watch policy did not include notification of the Indiana State Department of Health, which is the authority having jurisdiction. Based on interview at the time of record review, the Maintenance Manager stated no additional fire watch documentation was available for review and acknowledged the written fire watch policy did not include the aforementioned statements.</p> <p>3.1-19(b)</p>		and recommendation.		