

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2013
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NAME OF PROVIDER OR SUPPLIER  SUGAR CREEK REHABILITATION AND CONVALESCENT CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140
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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: 11/20/13</p> <p>Facility Number: 000157 Provider Number: 155254 AIM Number: 100274720</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Sugar Creek Rehabilitation &amp; Convalescent Center was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping</p>	K010000	<p>This plan of correction is to serve as Sugar Creek Rehabilitation Convalescent Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Sugar Creek Rehabilitation Convalescent Center or its management company that the allegations contained in the report are a true and accurate portrayal of the provision of nursing care and other services in the facility, not does this submission constitute an agreement or admission of the survey allegation.</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>rooms. The facility has a capacity of 60 and had a census of 50 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached storage buildings, one Maintenance Shop and one storage shed housing the emergency generator transfer switch and sprinkler system riser.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/25/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010015 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to provide documentation of the flame spread rating for interior finish materials installed in 2 of over 40 rooms. This deficient practice could affect 30 residents, staff or visitors in the vicinity of the Director of Nursing (DON) Office.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 11/20/13, three walls of the closet to Room 1 and all four walls of the DON Office had wood paneling installed on the entire wall from floor to ceiling. Based on interview at the time of the observations, the Maintenance Director stated none of the walls had been treated with flame retardant material and acknowledged flame spread rating documentation was not available for</p>	K010015	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents or staff were affected by the alleged deficient practice. The facility realizes that residents or staff could be affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken The maintenance director will paint room 1 and all four walls of the DON office with flame retardant paint and have appropriate documentation to show compliance. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance Director will make quarterly rounds to ensure future compliance and or any alterations to facility which fall under these corrective actions How the corrective action(s) will be</p>	12/20/2013	

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	review for the wood paneling installed at the aforementioned locations.  3.1-19(b)		monitored to ensure the deficient practice will not recur;. The Maintenance Director will monitor quarterly for future compliance and submit to the administrator quarterly with any changes By what date the systemic changes will be completed; The needed repair as cited will be completed by 12/20/13.		

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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 40 corridor doors was provided with a means suitable for keeping the door closed and would resist the passage of smoke. This deficient practice could affect 30 residents, staff and visitors in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 11/20/13, the south door in the set of double doors to the kitchen from the Main Dining Room was not equipped with a positive latching device to ensure the door set would latch into the door frame. In</p>	K010018	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents or staff were affected by the alleged deficient practice. The facility realizes that residents or staff could be affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. The Maintenance Director will ensure that the south door in the set of double doors to the kitchen from the Main Dining Room is equipped with a positive latching device to ensure the door set will latch into the door frame. In addition, the meeting edge of the aforementioned door set will be equipped with an astragal, rabbet or bevel to resist the</p>	12/20/2013			

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	<p>addition, the meeting edge of the aforementioned door set was not equipped with an astragal, rabbet or bevel to resist the passage of smoke and there was gap of one half inch when the door set was closed. The Main Dining Room is open to the corridor. Based on interview at the time of observation, the Maintenance Director acknowledged the south door in the aforementioned door set was not equipped with a positive latching device which failed to provide a means suitable for keeping the door set closed and failed to resist the passage of smoke.</p> <p>3.1-19(b)</p>		<p>passage of smoke through the doors. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance Director will make quarterly rounds to ensure future compliance and or any alterations to facility which fall under these corrective actions How the corrective action(s) will be monitored to ensure the deficient practice will not recur;. The Maintenance Director will monitor quarterly for future compliance and submit to the administrator quarterly with any changes By what date the systemic changes will be completed; 12/20/2013</p>		

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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 record review, observation and interview; the facility failed to ensure the 1 of 1 kitchen rolling fire doors in the opening between the kitchen and the Main Dining room is held open only by a device arranged to automatically close upon activation of the fire alarm system. This deficient practice could affect 30 residents, staff and visitors in the vicinity of the Main Dining room.</p> <p>Findings include:</p> <p>Based on review of SafeCare "Service Call Report" documentation dated 09/30/13 with the Maintenance Director during record review from 9:15 a.m. to 11:45 a.m. on 11/20/13, the annual kitchen rolling door inspection report stated "Inspected window, works</p>	K010021	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents or staff were affected by the alleged deficient practice. The facility realizes that residents or staff could be affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? The Maintenance Director will ensure that the kitchen rolling fire doors in the opening between the kitchen and the Main Dining room are arranged to automatically close upon activation of the fire alarm system. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance</p>	12/20/2013			

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	<p>mechanically, but isn't tied into fire alarm." Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 11/20/13, the kitchen adjoins the Main Dining room and one serving window from the adjoining kitchen has a rolling fire door equipped with a fusible link. The Main Dining room was not separated from the corridor because there are no entry doors to the Main Dining room from the corridor. Based on interview at the time of interview and of the observation, the Maintenance Director stated the rolling fire door does not close upon activation of the fire alarm system, no repair or replacement documentation following the 09/30/13 inspection was available for review and acknowledged the kitchen rolling fire door does not close upon activation of the fire alarm system.</p> <p>3.1-19(b)</p>		<p>Director will make quarterly rounds to ensure future compliance and or any alterations to facility which fall under these corrective actions How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The Maintenance Director will monitor quarterly for future compliance and submit to the administrator quarterly with any changes By what date the systemic changes will be completed? 12/20/2013</p>		

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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 18 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 11/20/13, the following was noted:</p> <p>a. a six inch in diameter opening in the ceiling next to the outside air supply ductwork to the East Hall boiler room. In addition, a two inch in diameter open pipe for the passage of two cables penetrated the ceiling of the East Hall boiler room. Each of the aforementioned openings in the East Hall boiler room ceiling did not provide at least a one half hour fire</p>	K010025	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents or staff were affected by the alleged deficient practice. The facility realizes that residents or staff could be affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? The Maintenance Director will ensure that the following issues are resolved: a. a six inch in diameter opening in the ceiling next to the outside air supply ductwork to the East Hall boiler room. In addition, a two inch in diameter open pipe for the passage of two cables penetrated the ceiling of the East Hall boiler room. Each of the aforementioned openings in the East Hall boiler room ceiling did not provide at least a one half hour fire resistance rating. b. two,</p>	12/20/2013	

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	<p>resistance rating.</p> <p>b. two, three inch in diameter openings in the ceiling of the main fire alarm panel closet inside the Mideast Hall Shower Room did not provide at least a one half hour fire resistance rating for the closet ceiling.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged each of the aforementioned openings in the ceiling smoke barrier did not provide at least a one half hour fire resistance rating for the ceiling smoke barrier.</p> <p>3.1-19(b)</p>		<p>three inch in diameter openings in the ceiling of the main fire alarm panel closet inside the Mideast Hall Shower Room did not provide at least a one half hour fire resistance rating for the closet ceiling. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance Director will make quarterly rounds to ensure future compliance and or any alterations to facility which fall under these corrective actions How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The Maintenance Director will monitor quarterly for future compliance and submit to the administrator quarterly with any changes By what date the systemic changes will be completed? 12/20/2013.</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>1. Based on observation and interview, the facility failed to ensure 1 of 6 hazardous areas such as the kitchen was separated from other spaces by smoke resistant partitions and self closing doors which latched securely into their door frames. This deficient practice could affect 30 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 11/20/13, the south door in the set of double doors to the kitchen from the Main Dining Room was not equipped with a self closing device and a positive latching device to ensure the door set would self close and latch into the door frame. In addition, there is a one half inch gap between the meeting edge of the north</p>	K010029	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents or staff were affected by the alleged deficient practice. The facility realizes that residents or staff could be affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? The Maintenance Director will ensure that the following issues are resolved: The south door in the set of double doors to the kitchen from the Main Dining Room is equipped with a positive latching device to ensure the door set will latch into the door frame. In addition, the meeting edge of the aforementioned door set will be equipped with an astragal, rabbet or bevel to resist the passage of smoke through the doors. The kitchen rolling fire</p>	12/20/2013			

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	<p>door and the south door which would fail to resist the passage of smoke when the door set was closed. Based on interview at the time of observation, the Maintenance Director acknowledged the south door in the aforementioned door set was not equipped with a self closing device, a positive latching device and the aforementioned door set had a one half inch gap between the meeting edge which failed to separate the kitchen from other spaces by smoke resistant doors.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 6 doors serving hazardous areas such as fuel fired heater rooms are provided with self closing devices to close and latch each door into the door frame. This deficient practice could affect 2 residents and staff inside the Mideast Hall Shower Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 11/20/13, the entry door to the natural gas fired furnace room inside the Mideast Hall Shower Room was not equipped with a self closing device to close and latch the door into the door frame. Based</p>		<p>doors in the opening between the kitchen and the Main Dining room will be arranged to automatically close upon activation of the fire alarm system. The entry door to the natural gas fired furnace room inside the Mideast Hall Shower Room will be equipped with a self-closing device to close and latch the door into the door frame. A six inch in diameter opening in the ceiling next to the outside air supply ductwork to the East Hall boiler room. In addition, a two inch in diameter open pipe for the passage of two cables penetrated the ceiling of the East Hall boiler room. Each of the aforementioned openings in the East Hall boiler room ceiling did not provide at least a one half hour fire resistance rating. Two, three inch in diameter openings in the ceiling of the main fire alarm panel closet inside the Mideast Hall Shower Room did not provide at least a one half hour fire resistance rating for the closet ceiling. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance Director will make quarterly rounds to ensure future compliance and or any alterations to facility which fall under these corrective actions How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The Maintenance Director will monitor</p>				

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	<p>on interview at the time of observation, the Maintenance Director acknowledged the aforementioned hazardous area entry door inside the Mideast Hall Shower Room was not equipped with a self closing device to close and latch the door into the door frame.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure ensure 1 of 6 hazardous areas such as fuel fired heater rooms was separated from other spaces by smoke resistant partitions. This deficient practice could affect 18 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 11/20/13, a six inch in diameter opening in the ceiling next to the outside air supply ductwork was noted in the East Hall Boiler Room. In addition, a two inch in diameter open pipe for the passage of two cables penetrated the ceiling of the East Hall Boiler Room. Each of the aforementioned openings in the East Hall Boiler Room ceiling did not separate the room from other spaces by smoke resistant partitions. Based on interview at</p>		<p>quarterly for future compliance and submit to the administrator quarterly with any changes By what date the systemic changes will be completed? 12/20/2013.</p>				

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NAME OF PROVIDER OR SUPPLIER  SUGAR CREEK REHABILITATION AND CONVALESCENT CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140
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	<p>the time of the observations, the Maintenance Director acknowledged each of the aforementioned openings in the East Hall Boiler Room ceiling did not separate the room from other spaces by smoke resistant partitions.</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 annual testing of emergency lighting in accordance with LSC 7.9 for 4 of 5 battery powered lights for 12 months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour 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" testing documentation dated 12/03/12 through 11/01/13 during record review with the Maintenance Director from 9:15 a.m. to 11:45 a.m. on 11/20/13, documentation of an annual ninety minute test for four of five battery operated emergency lights within the most recent twelve month period was not available for review. Four battery operated emergency</p>	K010046	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents or staff were affected by the alleged deficient practice. The facility realizes that residents or staff could be affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? The Maintenance Director will be re-educated as to the requirement for annual documentation of testing of the battery systems for emergency lighting. Annual testing will be documented and kept in an emergency binder. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director will review documentation for annual testing upon quarterly rounds. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The Maintenance Director will report quarterly rounds to administrator. By what date the systemic changes will be completed? 12/20/2013</p>	12/20/2013			

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	<p>lights are installed inside the facility and one battery operated emergency light is installed at the emergency generator location outside the facility. Based on interview at the time of record review, the Maintenance Director stated an annual 90 minute functional test is only performed for the emergency generator light location and acknowledged annual testing documentation for each of four battery operated emergency lights installed inside the facility was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 11/20/13, each of the five battery operated emergency lights functioned when their respective test button was depressed.</p> <p>3.1-19(b)</p>			

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K010048 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</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 42 of 42 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 all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Disaster Action Plan: Fire Prevention, Fire Policy &amp; Procedure and General Action Fire Plan" documentation with the Maintenance Director during record review from 9:15 a.m. to 11:45 a.m. on 11/20/13, the</p>	K010048	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents or staff were affected by the alleged deficient practice. The facility realizes that residents or staff could be affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? The Administrator will ensure that the written Disaster Action Plan will be amended to include the following: The staff response to activation of the battery operated smoke detectors in the resident sleeping rooms. The use of K class fire extinguishers in conjunction with the fire suppression system in the kitchen overhead hood. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? The Administrator and the Maintenance Director will review the Disaster Action Plan upon completion and annually. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The regional team will review the plan upon their regular visits to ensure</p>	12/20/2013

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	<p>facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in each of 42 resident sleeping rooms. Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 11/20/13, battery operated smoke detectors were installed in each resident sleeping room. Based on interview at the time of record review, the Maintenance Director acknowledged the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in 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 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> </ol>		<p>completion. By what date the systemic changes will be completed? 12/20/2013</p>				

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	<p>(7) Preparation of floors and building for evacuation</p> <p>(8) Extinguishment of fire This deficient practice could affect three kitchen staff.</p> <p>Findings include:</p> <p>Based on review of "Disaster Action Plan: Fire Prevention, Fire Policy &amp; Procedure and General Action Fire Plan" documentation with the Maintenance Director during record review from 9:15 a.m. to 11:45 a.m. on 11/20/13, the fire disaster plan did not address the use of the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 11/20/13, a K-class fire extinguisher was located in the kitchen. Based on interview at the time of record review, the Maintenance Director 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 the K-class fire extinguisher.</p> <p>3.1-19(a)</p>				

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K010050 SS=F	<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 document fire drills conducted on the third shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Record" documentation during record review with the Maintenance Director from 9:15 a.m. to 11:45 a.m. on 11/20/13, documentation of a fire drill conducted on the third shift for the first quarter of 2013 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of a third shift fire drill conducted in the first quarter of 2013 was not available for review.</p> <p>3.1-19(b)</p>	K010050	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents or staff were affected by the alleged deficient practice. The facility realizes that residents or staff could be affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? The Maintenance Director will be re-educated as to the necessity for fire drills to be completed on all shifts as to comply with the regulation. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? A regular rotational schedule will be put in place by the administrator to ensure that all shifts are put through random fire drills and documented as such. How the corrective action(s) will be monitored to ensure the deficient</p>	12/20/2013			

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			practice will not recur? The Administrator and Maintenance Director will review documentation of fire drill completion quarterly. By what date the systemic changes will be completed? 12/20/2013		

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K010052 SS=C	<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 ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.</p>	K010052	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents or staff were affected by the alleged deficient practice. The facility realizes that residents or staff could be affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? The Maintenance Director will ensure that he circuit disconnecting means for the fire alarm system at the storage shed emergency generator breaker panel is enclosed in a locked or sealed cabinet, labeled as FIRE ALARM CIRCUIT CONTROL, with a red marking and accessible only to authorized personnel. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance Director will make quarterly rounds to ensure future compliance and or any alterations to facility which fall under these corrective actions How the</p>	12/20/2013			

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 11/20/13, the emergency generator transfer switch is located in an unlocked detached storage shed and facility operations powered by the emergency generator are located in one unlocked breaker panel in the detached shed. Three breakers labeled "Emer. Lighting Panel" in the storage shed breaker panel serve a subpanel inside the east wing of the facility at the corridor smoke barrier door set. The fire alarm system breaker in the east wing subpanel was identified and locked. The circuit disconnecting means for the fire alarm system at the storage shed emergency generator breaker panel was not enclosed in a locked or sealed cabinet, was not labeled as FIRE ALARM CIRCUIT CONTROL, with a red marking and was not accessible only to authorized personnel. Based on interview at the time of observation, the Maintenance Director acknowledged the fire alarm system breaker located at the emergency generator transfer switch in the detached storage shed was not identified and accessible only to authorized personnel.</p> <p>3.1-19(b)</p>		<p>corrective action(s) will be monitored to ensure the deficient practice will not recur? The Maintenance Director will monitor quarterly for future compliance and submit to the administrator quarterly with any changes By what date the systemic changes will be completed? 12/20/2013</p>				

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K010056 SS=A	<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>Based on observation and interview, the facility failed to ensure the sprinkler system was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. These deficient practices could affect two residents and staff in the Mideast Hall Shower Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 11/20/13, a 30 inch horizontal length of</p>	K010056	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents or staff were affected by the alleged deficient practice. The facility realizes that residents or staff could be affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? The Maintenance Director will ensure that Safecare will install a supporting bracket on the 30 inch horizontal length of steel sprinkler pipe protruding from the wall in the natural gas fired furnace room inside the Mideast Hall Shower Room. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? The</p>	12/20/2013			

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	<p>steel sprinkler pipe protruding from the wall in the natural gas fired furnace room inside the Mideast Hall Shower Room was unsupported to a sprinkler. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler location was an unsupported armover greater than 24 inches in length for a steel pipe.</p> <p>3.1-19(b)</p>		<p>maintenance Director will make quarterly rounds to ensure future compliance and or any alterations to facility which fall under these corrective actions How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The Maintenance Director will monitor quarterly for future compliance and submit to the administrator quarterly with any changes By what date the systemic changes will be completed? 12/20/2013</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, observation, and interview; the facility failed to ensure 11 of 11 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 record review with the Maintenance Director from 9:15 a.m. to 11:45 a.m. on 11/20/13, documentation of fire damper inspection and maintenance</p>	K010067	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents or staff were affected by the alleged deficient practice. The facility realizes that residents or staff could be affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Maintenance Director will be re-educated as the requirement for fire damper inspection at least every four years and for the documentation to be readily accessible. The Maintenance Director will ensure that arrangements are made for inspection of the fire dampers and retain this documentation in the life safety binder at the facility. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance Director will make quarterly rounds to ensure future compliance and or any alterations to facility which fall under these corrective actions How the corrective action(s) will be monitored to ensure the</p>	12/20/2013			

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	<p>performed within the most recent four year period was not available for review. Review of Life Safety Services "Project Summary" documentation dated 11/24/08 for fire damper inspection and maintenance indicated 11 fire dampers were located in the facility and this inspection and maintenance was performed more than four years ago. Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 11/20/13, one fire damper was observed installed in the furnace in the Dining Room near the patio exit. Based on interview at the time of record review and of the observation, the Maintenance Director stated fire dampers are installed at furnace locations, no additional fire damper inspection and maintenance documentation was available for review and acknowledged documentation of facility fire damper inspection and maintenance performed within the most recent four year period was not available for review.</p> <p>3.1-19(b)</p>		<p>deficient practice will not recur? The Maintenance Director will monitor quarterly for future compliance and submit to the administrator quarterly with any changes By what date the systemic changes will be completed? 12/20/2013</p>				

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K010069 SS=A	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure 3 of 3 kitchen range hood fire suppression system nozzles were provided with blowoff caps or other suitable devices to prevent the entrance of grease vapors into the nozzles. LSC 9.2.3 requires commercial cooking equipment to be in compliance with NFPA 96, 1998 Edition, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 7-2.2.1 requires automatic fire extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable:</p> <ul style="list-style-type: none"> <li>a. NFPA 12, Standard on Carbon Dioxide Extinguishing Systems</li> <li>b. NFPA 13, Standard for the Installation of Sprinkler Systems</li> <li>c. NFPA 17, Standard for Dry Chemical Extinguishing Systems</li> <li>d. NFPA 17A, Standard for Wet Chemical Extinguishing Systems</li> </ul> <p>NFPA 17A, Standard for Wet Chemical Extinguishing Systems, 1998 Edition, 2-3.1.4 states all discharge nozzles shall be provided with caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign</p>	K010069	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents or staff were affected by the alleged deficient practice. The facility realizes that residents or staff could be affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? The Maintenance Director will ensure that all kitchen range hood fire suppression system nozzles are provided with blow-off caps or other suitable devices to prevent the entrance of grease vapors into the nozzles. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance Director will make quarterly rounds to ensure future compliance and or any alterations to facility which fall under these corrective actions How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The Maintenance Director will monitor quarterly for future compliance and submit to the administrator quarterly with any changes By what date the systemic changes will be completed? 12/20/2013</p>	12/20/2013			

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	<p>materials into the piping. The protection device shall blow off, open, or blow out upon agent discharge. This deficient practice could affect three staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 11/20/13, each of three kitchen range hood fire suppression system nozzles were not provided with blowoff caps or other suitable devices to prevent the entrance of grease vapors into the nozzles. Based on interview at the time of observation, the Maintenance Director acknowledged the three kitchen range hood fire suppression system nozzles were not provided with blowoff caps or other suitable devices to prevent the entrance of grease vapors into the nozzles.</p> <p>3.1-19(b)</p>			

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K010144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to ensure overcurrent protective devices in Emergency Power Supply Systems (EPSS) circuits were accessible only to authorized persons. Chapter 3-4.4.1.1 of NFPA 99 states the generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be maintained in accordance with NFPA 110. NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition, 4-5.3 states overcurrent devices in EPSS circuits shall be accessible to authorized persons only. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 11/20/13, the emergency generator transfer switch is located outside the facility in an unlocked detached storage shed. Facility operations powered by the emergency generator are located in one unlocked breaker panel in the detached</p>	K010144	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents or staff were affected by the alleged deficient practice. The facility realizes that residents or staff could be affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? The Maintenance Director will ensure the following: The emergency generator and the breaker for said generator are secured and accessible only to authorized personnel. Inspections of the starting batteries of the emergency generator will be conducted weekly and documented as such. This documentation will be retained in the life safety binder at the facility. Documentation of reliability from the off-site natural gas supplier for the emergency generator will be obtained and placed in the life safety binder at the facility. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance Director will make quarterly</p>	12/20/2013			

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	<p>shed. Based on interview at the time of observation, the Maintenance Director acknowledged the emergency generator transfer switch and facility operations powered by the emergency generator are located in an unlocked detached storage shed outside the facility.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 40 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff</p>		<p>rounds to ensure future compliance and or any alterations to facility which fall under these corrective actions How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The Maintenance Director will monitor quarterly for future compliance and submit to the administrator quarterly with any changes By what date the systemic changes will be completed? 12/20/2013</p>		

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	<p>and visitors.</p> <p>Findings include:</p> <p>Based on review of "Generator Testing" documentation with the Maintenance Director during record review from 9:15 a.m. to 11:45 a.m. on 11/20/13, documentation of weekly inspections of the starting batteries for the emergency generator for 40 of 52 weeks was not available for review. The facility documented generator starting battery inspection once per month for the twelve month period of 12/31/12 through 11/06/13 but does not document inspections of the starting batteries on a weekly basis. Based on interview at the time of record review, the Maintenance Director stated the facility documents monthly inspection of the starting batteries and acknowledged documentation of weekly battery inspections during the aforementioned twelve month period was not available for review.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to ensure documentation of the reliability for the off site fuel source for 1 of 1 emergency generators was available for review. NFPA 110</p>				

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	<p>1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <ul style="list-style-type: none"> <li>a) Liquid Petroleum products at atmospheric pressure</li> <li>b) Liquefied petroleum gas (liquid or vapor withdrawal)</li> <li>c) Natural or synthetic gas</li> </ul> <p>Exception: For Level 1 installations in locations where the probability of interruption of offsite fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all clients, staff and visitors. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:</p> <ul style="list-style-type: none"> <li>1. A statement of reasonable reliability of the natural gas delivery.</li> <li>2. A brief description that supports the statement regarding the reliability.</li> </ul>			

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	<p>3. A statement that there is a low probability of interruption of the natural gas.</p> <p>4. A brief description that supports the statement regarding the low probability of interruption,</p> <p>5. The signature of a technical person from the natural gas provider.</p> <p>This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:15 a.m. to 11:45 a.m. on 11/20/13, documentation of reliability from the off site natural gas supplier for the emergency generator was not available for review. Based on interview at the time of record review, the Maintenance Director stated the fuel source for the emergency generator was natural gas and acknowledged documentation of reliability from the natural gas provider was not available for review.</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 order to protect 50 of 50 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> <p>Based on review of "Disaster Action Plan: Fire Watch Policy &amp; Procedure"</p>	K010154	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents or staff were affected by the alleged deficient practice. The facility realizes that residents or staff could be affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? The Disaster Action Plan for the facility will be amended such that the written fire watch policy will include notification of the insurance carrier and alarm company in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance Director will make quarterly rounds to ensure future compliance and or any alterations to facility which fall under these</p>	12/20/2013

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	<p>documentation with the Maintenance Director during record review from 9:15 a.m. to 11:45 a.m. on 11/2013, the fire watch policy did not include notification of the insurance carrier and alarm company in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period. Based on interview at the time of record review, the Maintenance Director stated no additional fire watch documentation was available for review and acknowledged the written fire watch policy did not include notification of the insurance carrier and alarm company in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period.</p> <p>3.1-19(b)</p>		<p>corrective actions How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The Maintenance Director will monitor quarterly for future compliance and submit to the administrator quarterly with any changes By what date the systemic changes will be completed? 12/20/2013</p>	