

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155324	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2014
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NAME OF PROVIDER OR SUPPLIER MITCHELL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 24 TEKE BURTON DR MITCHELL, IN 47446
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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: 07/30/14</p> <p>Facility Number: 000217 Provider Number: 155324 AIM Number: 100289590</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Mitchell Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and in spaces open to the corridors, plus battery powered smoke detectors in all resident</p>	K010000	<p>This plan of correction is prepared and executed because of the provisions of State and federal law require it and not because Mitchell Manor agrees with the allegations and citations listed. Mitchell Manor maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character so as to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance, that the alleged deficiencies cited have been or will be corrected by the date(s) indicated. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following Plan of Correction.</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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K010018 SS=E	<p>sleeping rooms. The facility has a capacity of 171 and had a census of 57 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except a garage and two storage barns used for facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/11/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 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</p>						

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	<p>regulations in all health care facilities.</p> <p>1. Based on observation and interview, the facility failed to ensure there was no impediment to closing doors, and ensuring doors would latch into their door frames, in 4 of 10 smoke compartments. This deficient practice could affect up to 33 residents, plus staff and visitors in the A and D Wings, plus any number of residents, staff and visitors while in the entrance corridor and Williams Wing which includes the Physical Therapy Unit.</p> <p>Findings include:</p> <p>Based on observations on 07/30/14 between 3:00 p.m. and 6:00 p.m. during a tour of the facility with Maintenance Assistant # 1 and the Executive Director, the following doors protecting corridor openings were held open with items:</p> <p>a. Copy room in the front entrance corridor by a waste basket</p> <p>b. Resident room 116 in the A Wing by a waste basket</p> <p>c. Room 209 in the Williams Wing (unoccupied) by a bed frame</p> <p>Furthermore, the door latching device for resident room 174 was installed backwards, so the door would not latch into its frame.</p> <p>These items were acknowledged by Maintenance Assistant # 1 and the</p>	K010018	<p>K018 – It is the policy of Mitchell Manor to maintain doors protecting corridor openings in a manner consistent with NFPA 101 Life Safety Code standards. I</p> <p>1. The waste baskets in the copy room and resident room 116 were moved so that they do not obstruct the door. The bed in room 209 was moved so that it does not obstruct the door. The latching device for room 174 was reversed so that it correctly latches into the door frame.</p> <p>2. Complete tour of the facility was conducted. No other obstructions to corridor doors were identified.</p> <p>3. Maintenance Director or designee will incorporate monthly door rounds into their routine. Staff will be educated when /if door obstructions are identified during rounds.</p> <p>4. Door round logs will be presented during the monthly facility Quality Improvement committee meetings X 4 months.</p> <p>II</p> <p>1. The double doors to the Williams Wing Kitchenette have been corrected so that they automatically achieve a positive latch.</p> <p>2. Complete tour of facility was conducted. All doors protecting corridor openings achieve a positive latch.</p> <p>3. Maintenance Director or designee will incorporate monthly</p>	08/28/2014
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	<p>Executive Director at the time of each observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 sets of double doors to the corridor were equipped with positive latches and latched into the door frame. This deficient practice could affect any number of residents, as well as staff and visitors while in the Williams Wing (which was unoccupied, but was between all other resident room corridors and the Physical Therapy Unit).</p> <p>Findings include:</p> <p>Based on observation on 07/30/14 at 4:01 p.m. during a tour of the facility with Maintenance Assistant # 1 and the Executive Director, the set of double doors to the Williams Wing kitchenette did not automatically latch positively into the door frame, one door had to be manually latched with a built in slidebolt latch located at the top back side of the door. This was acknowledged by Maintenance Assistant # 1 and the Executive Director at the time of observation.</p> <p>3.1-19(b)</p>		<p>door rounds into their routine. Doors protecting corridor openings that do not achieve positive latch will be corrected at the time of inspection.</p> <p>4. Door round logs will be presented during the monthly facility Quality Improvement committee meetings X 4 months.</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 the ceiling smoke barrier in 1 of 10 smoke compartments provided at least a 30 minute fire resistance rating. LSC 8.3.2 requires smoke barriers to extend from an outside wall to an outside wall. This deficient practice could affect over 10 residents, as well as staff and visitors while in the Education Wing which included the Activity Room.</p> <p>Findings include:</p> <p>Based on observation on 07/30/14 at 5:45 p.m. during a tour of the facility with Maintenance Assistant # 1 and the Executive Director, the two foot by four foot attic access panel in the Educational</p>	K010025	<p>K025 – It is the policy of Mitchell Manor to ensure that smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3 of the NFPA 1010 Life Safety Code Standard.</p> <p>1. The attic access panel in the Education Hall has been fitted with a drywall insert that will provide 30 minute fire rated protection.</p> <p>2. All access panels in the facility have been inspected and meet NFPA 101 Life Safety Code Standards.</p> <p>3. Any additional planned installations of attic access panels will be reviewed for compliance with NFPA 101 Life Safety Code Standards before they are placed.</p> <p>4. Maintenance Director will bring any concerns regarding appropriate fire ratings of physical</p>	08/28/2014

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K010029 SS=E	<p>Wing corridor was made of one quarter inch plywood construction which did not provide at least a 30 minute fire resistance rating. This was acknowledged by Maintenance Assistant # 1 and the Executive Director at the time of observation.</p> <p>3.1-19(b)</p> <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 2 of 12 hazardous area room doors, such as a room over 50 square feet containing combustible material, were equipped with self closing devices on the doors. This deficient practice could affect mostly staff in the unoccupied C Wing and 11 residents, as well as staff and visitors in the D Wing.</p> <p>Findings include:</p>	K010029	<p>plant items to the Executive Director's attention so that appropriate corrective actions can be taken.</p> <p>K029 – It is the policy of Mitchell Manor to ensure that fire rated doors protecting hazardous areas are equipped with self-closure devices.</p> <p>1. The Medical Records storage room entry door was fitted with a self-closing device. The linen containers that were identified in room 165 have been moved to the appropriate soiled utility room.</p> <p>2. Complete tour of facility reveals that all other areas housing potentially hazardous</p>	08/28/2014			

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K010038 SS=E	<p>Based on observations on 07/30/14 between 3:00 p.m. and 6:00 p.m. during a tour of the facility with Maintenance Assistant # 1 and the Executive Director, the following was noted:</p> <p>a. Room 155 was over 50 square feet in size and was being used as a Medical Records storage room and contained over 50 plastic totes full of paper records. There was no self closing device on the door.</p> <p>b. Room 165 was over 50 square feet in size and contained one soiled linen bin and one trash bin, both over 32 gallons and over half full of soiled linen and trash. There was no self closing device on the door. Furthermore, the soiled linen and trash bins were observed in this same room during the quick tour between 11:15 a.m. and 11:30 a.m.</p> <p>Based on interview at the time of each observation, Maintenance Assistant # 1 and the Executive Director both acknowledged the lack of self closers on the doors to rooms 155 and 165, furthermore, the Executive Director said the soiled linen and trash bins were not normally kept in room 165.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		<p>items are protected by fire rated doors with self-closing devices. Linen / trash containers are stored in appropriately designated areas.</p> <p>3.Maintenance Director or designee will incorporate monthly door rounds into their routine. All storage areas for potentially hazardous items will be audited to ensure they have self-closing devices installed.</p> <p>4.Door round logs will be presented during the monthly facility Quality Improvement committee meetings X 4 months.</p>				

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	<p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 21 exit access doors equipped with delayed egress locks and provided with signs stating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS, did open when pushed on for 15 seconds. 7.2.1.6.1, requires approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds</p>	K010038	<p>K038 – It is the policy of Mitchell Manor to ensure that fire exit access is arranged so that exits are readily accessible at all times in accordance with NFPA 101 Life Safety Code section 7.1. 19.2.1</p> <p>I</p> <p>1. The delayed egress lock for the Education Hall fire exit door was adjusted during the survey within the presence of the survey team. The door was functioning properly when the survey team and the facility staff left the area to continue their tour.</p> <p>2. Complete tour of the facility indicated that all delayed egress doors are functioning appropriately.</p> <p>3. Maintenance Director or designee will incorporate monthly door rounds into their routine. Delayed egress doors that are not functioning appropriately will be corrected at that time the problem is identified.</p> <p>4. Door round logs will be presented during the monthly facility Quality Improvement committee meetings X 4 months.</p> <p>II</p> <p>1. The exit egress outside the Education Hall exit door has been corrected so that it provides a smooth transition between surfaces and no longer poses a potential tripping hazard.</p>	08/28/2014			

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	<p>upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the releasing device, there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This deficient practice could affect up to 10 residents in the Education Wing which included the Activity Room, while using the Education Wing exit.</p> <p>Findings include:</p> <p>Based on observation on 07/30/14 at 4:30 p.m. during a tour of the facility with Maintenance Assistant # 1 and the Executive Director, the Education Wing exit door was equipped with a delayed egress lock and was provided with a sign</p>		<p>2. Completetour of facility exit egress areas was completed. All exit egress areas provide transitionsbetween surfaces that do not pose a tripping hazard.</p> <p>3. MaintenanceDirector or designee will incorporate monthly door rounds into their routine.Exit egress areas outside exit doors will be visually inspected for potentialtripping hazards.</p> <p>4. Doorround logs will be presented during the monthly facility Quality Improvementcommittee meetings X 4 months.</p>	

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	<p>stating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS, however, when the door was pushed several times for 15 seconds it did not release. This was acknowledged by Maintenance Assistant # 1 and the Executive Director at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure exit egress for 1 of 21 exits was arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires that means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.2 through 7.1.6.4. LSC Section 7.1.6.2 requires abrupt changes in elevation shall not exceed 1/4 inch. LSC Section 7.1.6.3 requires walking surfaces to be nominally level. This deficient practice could affect mostly staff in the unoccupied C Wing.</p> <p>Findings include:</p> <p>Based on observation on 07/30/14 at 4:42 p.m. during a tour of the facility with Maintenance Assistant # 1 and the Executive Director, the sidewalk outside</p>						

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K010048 SS=F	<p>the C Wing exit had a one and a half inch grade change where the concrete and asphalt surfaces meet, which could create a tripping hazard. Based on interview at the time of observation, Maintenance Assistant # 1 and the Executive Director acknowledged the one and a half inch grade change where the concrete and asphalt surfaces meet could be a tripping hazard.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 57 of 57 residents to accurately address all life safety systems such as the use of the K-class fire extinguisher in the kitchen, and staff response to battery operated smoke detectors in resident sleeping rooms, plus a system addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire</p>	K010048	<p>K048 – It is the policy of Mitchell Manor to maintain a written plan for the protection of all patients and for their evacuation in the event of an emergency.</p> <p>1.Fire Procedures have been updated to include use of K class fire extinguishers, use of overhead kitchen extinguishing systems, and proper techniques for responding to battery operated smoke detectors in sleeping quarters.</p> <p>2.All facility Fire Procedure manuals will be updated with revised policy.</p> <p>3.Facility staff will be re-trained in the updated fire procedures. Fire safety training will be held with all new employees and at</p>	08/28/2014			

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K010050 SS=F	<p>department</p> <p>(3) Response to alarms</p> <p>(4) Isolation of fire</p> <p>(5) Evacuation of immediate area</p> <p>(6) Evacuation of smoke compartment</p> <p>(7) Preparation of floors and building for evacuation</p> <p>(8) Extinguishment of fire</p> <p>This deficient practice could affect all occupants in the event of an emergency.</p> <p>Findings include:</p> <p>Based on a review of the Fire Procedure on 07/30/14 at 1:55 p.m. with Maintenance Assistant # 1 and the Executive Director present, the Fire Procedure did not address the use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system, and staff response to battery operated smoke detectors in resident sleeping rooms. Based on interview at the time of record review, Maintenance Assistant # 1 and the Executive Director acknowledged the Fire Procedure did not include the previously mentioned items.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times</p>		<p>least annually for all staff.</p> <p>4. Fire procedure manuals will be reviewed every 6 months by the Executive Director and the Director of Maintenance to ensure that they are complete and current.</p>		

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	<p>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>1. Based on record review and interview, the facility failed to ensure each documented fire drill included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department for 12 of 12 fire drills. LSC 19.7.1.2 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Tels Book on 07/30/14 at 11:45 a.m. with the Maintenance Assistant # 1 and the Executive Director present, documentation for all twelve fire drills during the past twelve months did not include information the monitoring company/fire department received the transmission of the fire alarm. Based on interview at the time of record review, Maintenance Assistant # 1 acknowledged</p>	K010050	<p>K050 – It is the policy of Mitchell Manor to hold fire drills at unexpected times under varying conditions, at least quarterly on each shift. I</p> <p>1. Fire drill procedure has been adjusted to ensure that verification of signal to the monitoring company is documented with each drill.</p> <p>2. Fire drill procedure has been adjusted to ensure that verification of signal to the monitoring company is documented with each drill.</p> <p>3. ED and the Maintenance Director will review drill logs monthly to verify that fire drills are being conducted appropriately.</p> <p>4. Compliance with fire drill procedures will be audited and brought to the monthly Quality Improvement meetings X 4 months.</p> <p>II</p> <p>1. Fire drill schedules have been updated to ensure that drills occur at varied times over all 3 shifts.</p> <p>2. Fire drill schedules have been updated to ensure that drills occur at varied times over all 3 shifts.</p> <p>3. ED and the Maintenance</p>	08/28/2014

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	<p>documentation for the fire drills did not include information the monitoring company/fire department received the transmission of the fire alarm.</p> <p>3-1.19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 2 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Tels Book on 07/30/14 at 11:45 a.m. with Maintenance Assistant # 1 and the Executive Director present, three of four first shift (day) fire drills were performed between 1:08 p.m. and 1:28 p.m., furthermore, three of four third shift (night) fire drills were performed between 10:49 p.m. and 11:44 p.m. During an interview at the time of record review, Maintenance Assistant # 1 acknowledged the times the first and third shift fire drills were performed and agreed the times were not varied enough.</p> <p>3-1.19(b)</p> <p>3. Based on record review and interview,</p>		<p>Director will review drill logs monthly to verify that fire drills are being conducted appropriately.</p> <p>4. Compliance with fire drill procedures will be audited and brought to the monthly Quality Improvement meetings X 4 months.</p> <p>III</p> <p>1. "a.m./ p.m." notations will be made on times documented in facility fire drill logs.</p> <p>2. "a.m./ p.m." notations will be made on times documented in facility fire drill logs.</p> <p>3. ED and the Maintenance Director will review drill logs monthly to verify that fire drills are being conducted appropriately.</p> <p>4. Compliance with fire drill procedures will be audited and brought to the monthly Quality Improvement meetings X 4 months</p>		

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K010051 SS=F	<p>the facility failed to ensure written documentation on 12 of 12 fire drills was complete. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Tels Book on 07/30/14 at 11:45 a.m. with Maintenance Assistant # 1 and the Executive Director present, all twelve documented fire drills lacked "a.m./p.m." for a time frame the drill was performed, however, each fire drill report did have a shift included. This was acknowledged by Maintenance Assistant # 1 at the time of record review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems</p>						

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	<p>are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure smoke detectors were not installed where air flow would adversely affect their operation where 1 of 1 fire alarm control panels was located. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation on 07/30/14 at 5:03 p.m. during a tour of the facility with Maintenance Assistant # 1 and the Executive Director, the smoke detector in the room where the Fire Alarm Control Panel was located within the air flow closer than three feet to the return air vent. This was acknowledged by Maintenance Assistant # 1 and the Executive Director at the time of observation.</p> <p>3.1-19(b)</p>	K010051	<p>K051 – It is the policy of Mitchell Manor to maintain a fire alarm system with approved components, devices, or equipment and is installed according to NFPA 72.</p> <p>1. The smoke detector in the room with the Fire Alarm Control Panel has been moved to a location that is farther away from the air return vent.</p> <p>2. Complete tour of facility performed and all smoke detectors are an appropriate distance from air return vents.</p> <p>3. Any additional planned installations of smoke detectors will be reviewed for compliance with NFPA 101 Life Safety Code Standards before they are placed.</p> <p>4. Maintenance Director will bring any concerns regarding placement of smoke detectors to the Executive Director's attention so that appropriate corrective actions can be taken.</p>	08/28/2014			

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K010052 SS=F	<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 record review and interview, the facility failed to ensure 15 of 78 smoke detectors had been tested for sensitivity. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall</p>	K010052	<p>K052 – It is the policy of Mitchell Manor to maintain a fire alarm system that is in compliance with NFPA 70 National Electrical Code and NFPA 72 standards.</p> <p>1.All 15 identified smoke detectors have been sensitivity tested and are operating appropriately.</p> <p>2.All facility smoke detectors have evidence of sensitivity testing and are compliant with NFPA standards.</p> <p>3.Any new installations / replacements of smoke detectors will be audited by Maintenance Director or designee to ensure they have been sensitivity tested atthe time of installation.</p> <p>4.Maintenance Director will bring any concerns regarding installation / replacement of smoke detectors to the Executive Director's attention so that appropriate corrective actions can be taken</p>	08/28/2014	

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	<p>be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires inspection, testing and maintenance reports be provided for the owner or a designated representative. It shall be the responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having jurisdiction. Paper or electronic media shall be acceptable. This deficient</p>			

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K010062 SS=F	<p>practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the smoke detector sensitivity records in the Tels Book on 07/30/14 at 1:27 p.m. with Maintenance Assistant # 1 and the Executive Director present, the most recent sensitivity test documentation available was dated 03/29/13 for 78 smoke detectors where 15 smoke detectors failed the sensitivity test. There was documentation to show the 15 smoke detectors were replaced on 04/11/13, however, the facility was not able to produce documentation to show if the 15 smoke detectors were tested for sensitivity within one year after installation. Based on interview at the time of record review, Maintenance Assistant # 1 and the Executive Director confirmed the 15 smoke detectors have not been tested for sensitivity.</p> <p>3.1-19(b)</p> <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>				

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	<p>1. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was maintained in reliable operating condition. LSC 101 at 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-11.1 requires maintenance shall be performed to keep the sprinkler system equipment operable or to make repairs. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's sprinkler system inspection reports in the Tels Book on 07/30/14 at 12:45 p.m. with Maintenance Assistant # 1 and the Executive Director present, the facility's dry sprinkler system inspection and testing report dated 04/10/14 stated: "During sprinkler inspection, found that Tyco accelerator on 4 inch CSC dry pipe valve in pit is not functional. Took accelerator apart and put it back together but still would not reset.", furthermore,</p>	K010062	<p>K062 – It is the policy of Mitchell Manor to continuously maintain a sprinkler system that is reliable operating condition and that is inspected and tested periodically.</p> <p>I</p> <ol style="list-style-type: none"> 1.The Tyco accelerator installed on the 4 inch dry pipe valve in the pit has been replaced. 2.No additional malfunctioning accelerators are present within the facility. 3.Maintenance Director and Executive Director will review Fire System Repair Orders monthly to ensure that all suggested repairs and maintenance have been performed. 4.Maintenance Director or designee will audit fire system repair orders for completion and report compliance in the Monthly Quality Improvement meetings X 4 months. <p>II</p> <ol style="list-style-type: none"> 1.The 3 sprinkler heads identified to have paint on them during the survey have been replaced. 2.Complete tour of facility was performed and no additional painted sprinkler heads were identified. 3.Maintenance Director or designee will round the facility quarterly to visually inspect all sprinkler heads ensuring that they are free of paint. 4.Sprinkler head audit results will be reviewed at the monthly Quality Improvement meeting held in the same month that the 	08/28/2014			

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	<p>"Maintenance wants to leave Tyco accelerator on reliable dry pipe valve off for now to drain low points!" During an interview at the time of record review, the Executive Director said the problem cited on the 04/10/14 sprinkler report has not been corrected but is scheduled to be completed soon.</p> <p>3-1.19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 3 of over 500 sprinkler heads in the facility were free of paint. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be free of paint. Any sprinkler shall be replaced that is painted. This deficient practice could affect any number of residents while around the large center nurses' station as well as kitchen staff and any resident using the room 165 shower room.</p> <p>Findings include:</p> <p>Based on observations on 07/30/14 between 3:00 p.m. and 6:00 p.m. during a tour of the facility with Maintenance Assistant # 1 and the Executive Director, the following locations had sprinkler</p>		<p>audit was performed X 12 months.</p> <p>III</p> <p>1.Internal pipe inspection has been performed.</p> <p>2.Internal pipe inspection has been performed.</p> <p>3.Maintenance Director and Executive Director will review Fire System Repair Orders monthly to ensure that all suggested repairs and maintenance have been performed.</p> <p>4.Maintenance Director or designee will audit fire system repair orders for completion and report compliance in the Monthly Quality Improvement meetings X 4 months.</p> <p>IV</p> <p>1.Sprinkler heads in the identified compartments (Rehab Dining Room and rooms 165, 166,168, 170, 172, and 174) have been adjusted so that each compartment has a consistent type of sprinkler head.</p> <p>2.Complete tour of facility did not reveal any additional compartments with mixed sprinkler head types.</p> <p>3.Maintenance Director or designee will round the facility quarterly to visually inspect all sprinkler heads ensuring that they are all of consistent type within the same compartment.</p> <p>4.Sprinkler head audit results will be reviewed at the monthly Quality Improvement meeting held in the same month that the audit was performed X 12</p>				

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	<p>heads partially covered with paint:</p> <p>a. The oxygen storage/transfer room</p> <p>b. The dishwashing room in kitchen</p> <p>c. The shower room in resident room 165</p> <p>This was acknowledged by Maintenance Assistant # 1 and the Executive Director the time of each observation.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to ensure 1 of 1 automatic dry sprinkler piping systems was inspected internally every five years. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 10-2.2 states sprinkler systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally of obstructions every 5 years. NFPA 25, in A-10-2.2 explains a dry pipe system using noncoated ferrous piping shall be thoroughly investigated for obstruction from corrosion after they have been in service for 15 year, 25 years and every 5</p>		<p>months.</p> <p>V</p> <p>1. Automatic sprinkler storage cabinets have been audited and sufficient supplies exist ensuring at least 2 spares of each type sprinkler head are present within the facility.</p> <p>2. Automatic sprinkler storage cabinets have been audited and sufficient supplies exist ensuring at least 2 spares for each type sprinkler head are present within the facility.</p> <p>3. Maintenance Director or designee will round the facility quarterly to visually inspect all sprinkler heads. Sprinkler supply cabinets will be inspected during rounds to ensure that sufficient numbers of spare sprinkler heads are available.</p> <p>4. Sprinkler head audit results will be reviewed at the monthly Quality Improvement meeting held in the same month that the audit was performed X 12 months.</p> <p>VI</p> <p>1. The ceiling tiles and escutcheons in: the corridor outside room 106, Oxygen Room, Vending Machine Room, Physical Therapy Treatment Room, Furnace Room, Soiled Linen Room next to the nurses station, Housekeeping Fill Station Closet next to the nurses station, and the room 165 bathroom have been repaired / replaced.</p> <p>2. Complete facility toured and no additional ceiling tile</p>				

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	<p>years thereafter. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's sprinkler system inspection reports in the Tels Book on 07/30/14 at 6:10 p.m. with Maintenance Assistant # 1 and the Executive Director present, there was no internal dry pipe inspection documentation available. During an interview at the time of record review, Maintenance Assistant # 1 and Executive Director acknowledged there was no internal dry pipe inspection for the sprinkler system's pipes available.</p> <p>3.1-19(b)</p> <p>4. Based on observation and interview, the facility failed to ensure only one type of sprinkler head, i.e., quick response or standard sprinklers was installed in a compartmented space in 2 of 10 smoke compartments. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a smoke compartment shall be changed. This deficient practice could affect up to 11 residents in the D</p>		<p>penetrations or missing escutcheons are evident.</p> <p>3.Maintenance Director or designee will round the facility quarterly to visually inspect all sprinkler heads. Any missing escutcheons will be replaced when they are identified. Maintenance Director or designee will visualize for penetrating openings in ceilings when doing sprinkler head rounds.</p> <p>4.Sprinkler head audit results will be reviewed at the monthly Quality Improvement meeting held in the same month that the audit was performed X 12 months.</p>		

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	<p>Wing, plus any number of residents while using the Rehab Dining Room.</p> <p>Findings include:</p> <p>Based on observations on 07/30/14 between 3:00 p.m. and 6:00 p.m. during a tour of the facility with Maintenance Assistant # 1 and the Executive Director, the Rehab Dining Room at the end of the B Wing plus the following resident sleeping rooms in the D Wing had a mixture of quick response sprinkler heads and standard response sprinkler heads: rooms 165, 166, 168, 170, 172, and 174. This was acknowledged by Maintenance Staff # 1 and the Executive Director at the time of each observation.</p> <p>3.1-19(b)</p> <p>5. Based on observation and interview, the facility failed to ensure 2 of 2 automatic sprinkler head storage cabinets were provided with at least two of each type of sprinkler head used in the facility. NFPA 25, 2-4.1.4 requires a minimum of two sprinklers of each type and temperature rating installed shall be stored in a cabinet on the premises for replacement purposes. This deficient practice could affect up to 25 residents, as well as staff and visitors while in the Rehab Dining Room.</p>			

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	<p>Findings include:</p> <p>Based on observations on 07/30/14 between 3:00 p.m. and 6:00 p.m. during a tour of the facility with Maintenance Assistant # 1 and the Executive Director, the two spare sprinkler head cabinets in the facility had more than six spare sprinkler heads each, however, there were no spare sidewall sprinkler heads available (observed in the Rehab Dining Room in the skylight area). This was acknowledged by the Maintenance Assistant # 1 and Executive Director at the time of observations, furthermore, the Maintenance Assistant # 1 indicated there were no other spare sprinkler heads in the facility.</p> <p>3-1.19(b)</p> <p>6. Based on observation and interview, the facility failed to ensure the ceiling/ceiling tiles in 5 of 10 sprinklered smoke compartments were maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect any number of resident, staff and visitors throughout the facility including around the center Nurses' Station area.</p> <p>Findings include:</p>			
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	<p>Based on observations on 07/30/14 between 3:00 p.m. and 6:00 p.m. during a tour of the facility with Maintenance Assistant # 1 and the Executive Director, the following locations had penetrations through the ceiling/ceiling tiles where there were gaps, sprinkler escutcheons missing, or both:</p> <p>a. The corridor outside room 106, the escutcheon was hanging down which created a one half inch gap around the sprinkler head and ceiling which was open to the attic space,</p> <p>b. Oxygen room with no escutcheon which created a one half inch gap around the sprinkler pipe and attic space,</p> <p>c. Vending machine room with no escutcheon which created a one half inch gap around the sprinkler pipe and attic space,</p> <p>d. Physical Therapy treatment room with no escutcheon which created a one half inch gap around the sprinkler pipe and attic space,</p> <p>e. Furnace Room for the main dining room had a six inch opening through the ceiling to the attic with air conditioning lines running through,</p> <p>f. Soiled linen room next to Nurses' Station, the escutcheon hanging down which created a one half inch gap around the sprinkler pipe and attic space,</p> <p>g. Housekeeping Fill Station closet next</p>			

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K010144 SS=F	<p>to Nurses' Station, the ceiling tiles have three holes all over two inches,</p> <p>h. Room 165 shower room with no escutcheon which created a one inch gap around the sprinkler pipe and attic space This was acknowledged by Maintenance Assistant # 1 and the Executive Director at the time of each observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating temperature conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least</p>	K010144	<p>K144 – It is the policy of Mitchell Manor to maintain generators that are inspected weekly and exercised under load for 30 minutes per month.</p> <p>1.Documentation of monthly generator load tests will be changed to include the KW transferred during each monthly load test.</p> <p>2.Documentation of monthly generator load tests will be changed to include the KW transferred during each monthly load test.</p> <p>3.Maintenance Director and Executive Director will review generator load test documentation monthly to ensure that transferred KW information is</p>	08/28/2014			

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	<p>monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Tels Book generator monthly load tests on 07/30/14 at 12:06 p.m. with Maintenance Assistant # 1 and the Executive Director present, the generator log form documented the generator was tested monthly under load, however, documentation showing the generator was exercised under operating temperature conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes during the past twelve months was always documented at 100% under the load column for the past twelve months. Furthermore, there was no information on the monthly log form to show how the 100% load was achieved. Finally, the generator was documented as a 7.2 KW generator on the generator monthly test log with no information provided as to the number of KW</p>		<p>included on test documents. 4. Maintenance Director or designee will audit generator load test documentation for completion and report compliance in the Monthly Quality Improvement meetings X 4months.</p>				

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K010147 SS=F	<p>transferred during each monthly load test. This was acknowledged by Maintenance Assistant # 1 at the time of record review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure power strips were not used as a substitute for fixed wiring in 7 of 79 resident rooms plus the Activity Room and the center Nurses' Station. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 10 residents in resident rooms plus any number of residents, as well as staff and visitors while in the Activity Room and around the center Nurses' Station.</p> <p>Findings include:</p> <p>Based on observations on 07/30/14</p>	K010147	<p>K147 – It is the policy of Mitchell Manor to maintain electrical wiring and equipment in a manner consistent with NFPA 70, National Electrical Code 9.1.2</p> <p>1.Power strips were removed from rooms: 101, 103, 115, 110, 108, 132, Activity room,168, and the Central Nurses' Station. Additional electrical receptacles were added to each resident room identified.</p> <p>2.Complete tour of facility was conducted. Additional electrical receptacles were added to all resident rooms in need of additional electrical service. Power strips were removed as they were identified.</p> <p>3.Maintenance Director or designee will make monthly rounds to ensure that power strips are not employed in ways that are not compliant with NFPA 70.</p> <p>4.Rounds logs will be reviewed at the monthly Quality Improvement meeting X 4 months.</p>	08/28/2014

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	<p>between 3:00 p.m. and 6:00 p.m. during a tour of the facility with Maintenance Assistant #1 and the Executive Director, the following was noted:</p> <ul style="list-style-type: none"> a. in Room 101, a bed was plugged into a power strip, b. in Room 103, a bed, oxygen concentrator, and small refrigerator were plugged into a power strip, c. in Room 115, a bed was plugged into a power strip, d. in Room 110, a bed was plugged into a power strip, e. in Room 108, a bed and an oxygen concentrator were plugged into two separate power strips, f. in Room 132, a bed, lift chair, and air mattress were plugged into a power strip, g. in the Activity Room, a medium size freezer was plugged into a power strip, h. in Room 168, a bed and oxygen concentrator were plugged into a power strip, i. in the Center Nurses' Station, a large floor fan was plugged into a power strip. <p>At the time of each observation, Maintenance Assistant # 1 and the Executive Director acknowledged the use of the power strips in resident rooms, the Activity Room, and center Nurses' Station.</p> <p>3.1-19(b)</p>			

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K010154 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 57 of 57 residents containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors at the time of this survey.</p> <p>Findings include:</p> <p>Based on review of the "Failure-Fire</p>	K010154	<p>K154 – It is the policy of Mitchell Manor to maintain a written guidance for responding to incidences in which the facility sprinkler system is out of service for more than 4 hours.</p> <p>1. The existing Facility Fire Watch Policy has been updated to include: Phone number to contact Indiana State Department of Health and a statement explaining that "fire watch is the only job/duty of the fire watch person".</p> <p>2. All facility Fire Procedure manuals will be updated with revised policy.</p> <p>3. Facility staff will be re-trained in the updated fire procedures. Fire safety training will be held with all new employees and at least annually for all staff.</p> <p>4. Fire procedure manuals will be reviewed every 6 months by the Executive Director and the Director of Maintenance to ensure that they are complete and current</p>	08/28/2014			

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K010155 SS=F	<p>Alarm System" on 07/30/14 at 6:05 p.m. with Maintenance Assistant # 1 and the Executive Director present, the facility did have a written policy and procedure for an impaired fire protection system, however, the fire watch policy did not include information to contact Indiana State Department of Health with a phone number, plus a statement that the fire watch is the only duty/job of the fire watch person. The lack of this documentation was acknowledge by Maintenance Assistant # 1 and the Executive Director at the time of record review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to provide a complete written policy for the protection of 57 of 57 residents containing procedures to be followed in the event the fire alarm system has to be placed out of services</p>	K010155	K155 – It is the policy of Mitchell Manor to maintain a written guidance for responding to incidences in which the facility sprinkler system is out of service for more than 4 hours. 1. The existing Facility Fire Watch Policy has been updated	08/28/2014

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	<p>for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all occupants in the facility including residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of the "Failure-Fire Alarm System" on 07/30/14 at 6:05 p.m. with Maintenance Assistant # 1 and the Executive Director present, the facility did have a written policy and procedure for an impaired fire protection system, however, the fire watch policy did not include information to contact Indiana State Department of Health with a phone number, plus a statement that the fire</p>		<p>to include: Phone numberto contact Indiana State Department of Health and a statement explaining that "firewatch is the only job/duty of the fire watch person".</p> <p>2.Allfacility Fire Procedure manuals will be updated with revised policy.</p> <p>3.Facilitystaff will be re-trained in the updated fire procedures. Fire safety training will be held with allnew employees and at least annually for all staff.</p> <p>4.Fireprocedure manuals will be reviewed every 6 months by the Executive Director andthe Director of Maintenance to ensure that they are complete and current.</p>				

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K010211 SS=E	<p>watch is the only duty/job of the fire watch person. The lack of this documentation was acknowledge by Maintenance Assistant # 1 and the Executive Director at the time of record review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>Based on observation and interview, the facility failed to ensure 1 of over 20 alcohol based hand rub dispensers were not installed over an ignition source. NFPA 101, in 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 could</p>	K010211	<p>K211 – It is the policy of Mitchell Manor to maintain Alcohol Based Hand Rub dispensers in a manner that is compliant with NFPA 101 Life Safety Code Standards.</p> <p>1. The Alcohol Based hand Rub dispenser located above the light switch in the Activity room has been moved.</p> <p>2. Complete tour of facility found all Alcohol Based Hand Rub</p>	08/28/2014

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	<p>affect 10 or more residents, as well as staff and visitors while in the Activity Room.</p> <p>Findings include:</p> <p>Based on observation on 7/30/14 at 4:25 p.m. during a tour of the facility with Maintenance Assistant # 1 and the Executive Director, the alcohol based hand rub dispenser in the Activity Room was mounted on the wall directly above a light switch. This was acknowledged by Maintenance Assistant # 1 and the Executive Director at the time of observation.</p> <p>3-1.19(b)</p>		<p>dispensers to be appropriately located.</p> <p>3. Maintenance Director and Maintenance staff were re-educated regarding appropriate placement of Alcohol Based Hand Rub dispensers. Maintenance Director or designee will perform quarterly rounds to evaluate placement of Alcohol Based Hand Rub dispensers.</p> <p>4. Results of quarterly rounds will be reviewed at the monthly Quality Improvement meeting held in the same month that the audit was performed X 12 months.</p>		