

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155271	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/16/2013
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NAME OF PROVIDER OR SUPPLIER MILLER'S SENIOR LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 8400 CLEARVISTA PL INDIANAPOLIS, IN 46256
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/16/13</p> <p>Facility Number: 000171 Provider Number: 155271 AIM Number: 100267050</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Miller's Senior Living Community 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 two story facility was determined to be of Type III (211) 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		

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 114 and had a census of 69 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing storage services which was not sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 07/18/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010020 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. Based on observation, record review and interview; the facility failed to maintain a one hour fire resistance rating for 2 of 4 exit stairs. This deficient practice could affect 40 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Assistant during a tour of the facility from 12:00 p.m. to 3:40 p.m. on 07/16/13, the stairwell access door on the first floor near the main entrance, on the second floor near the Breakroom and on the second floor near Room 236 each had a label affixed stating the fire resistance rating of each stairwell access door was twenty minutes. Based on interview at the time of the observations, the Maintenance Assistant acknowledged the fire resistance rating of each of the aforementioned stairwell access doors was twenty minutes.</p> <p>3.1-19(b)</p>	K010020	<p>K 020 NFPA 101 Life Safety Code Standard</p> <p>The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix K020.</p> <p>The corrective interventions of replacing the door will be accomplished for the safety of all residents.</p> <p>All residents that reside within the facility have the potential to be affected by this deficient practice. The corrections made protect all residents. An audit was completed of all other areas where a door accompanies a stairwell. Any doors found without at least a one hour fire resistance will be brought to code.</p>	08/15/2013			

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			<p>The doors will be replaced with doors that meet the requirement of a fire resistance rating of at least one hour.</p> <p>To ensure the deficient practice does not recur the facility will review Life Safety Code Standards during Quarterly rounds with our Regional Maintenance Supervisor. There will be a Quality Assurance Tool (attachment A) completed. This will be completed by the maintenance supervisor or designee.</p> <p>These systemic changes will be in place by August 15,2013.</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 openings through 2 of 10 smoke barrier walls on the first floor were protected to maintain the smoke resistance of the smoke barrier. This deficient practice could affect 30 residents staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Assistant during a tour of the facility from 12:00 p.m. to 3:40 p.m. on 07/16/13, the following was noted:</p> <p>a) a six inch diameter hole in the south wall of the mechanical room near the main entrance was not smoke resistant.</p> <p>b) a one foot by one foot rectangular hole in the north wall of the mechanical room in the service corridor next to dietary was not smoke resistant.</p> <p>Based on interview at the time of the observations, the Maintenance Assistant</p>	K010025	<p>K 025 NFPA 101 Life Safety Code Standard</p> <p>The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix K025.</p> <p>The corrective intervention of ensuring smoke barrier walls are protected to maintain smoke resistance will be accomplished for the safety of all residents.</p> <p>All residents that reside within the facility have the potential to be affected by this deficient practice. The corrections made protect all residents. An audit was completed of all other areas there</p>	08/15/2013			

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	acknowledged the aforementioned openings in the smoke barrier wall in each of the aforementioned mechanical rooms failed to maintain the smoke resistance of the smoke barrier. 3.1-19(b)		are smoke barrier walls. Any other areas noted will be corrected and brought into compliance. The two areas noted on inspection were repaired and sealed with a fire rated caulk to ensure smoke barrier walls are protected to maintain smoke resistance. All Maintenance staff will be educated to follow up on contractors after work is completed to ensure there that the smoke barrier walls have not been compromised while they are working on/near the smoke barrier walls. To ensure the deficient practice does not recur the facility will review Life Safety Code Standards during Quarterly rounds with our Regional Maintenance Supervisor. There will be a Quality Assurance Tool (attachment A) completed. This will be completed by the maintenance supervisor or designee. These systemic changes will be in place by August 15,2013.		

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K010029 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 hazardous areas such as fuel fired heater rooms smoke barrier walls were separated from other spaces by smoke resistant partitions and doors. This deficient practice could affect five staff and visitors in the vicinity of the first floor mechanical room in the service corridor next to dietary.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Assistant during a tour of the facility from 12:00 p.m. to 3:40 p.m. on 07/16/13, a one foot by one foot rectangular hole in the north wall of the mechanical room in the service corridor next to dietary was not smoke resistant. Based on interview at the time of observation, the Maintenance Assistant</p>	K010029	<p>K 029 NFPA 101 Life Safety Code Standard</p> <p>The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix K029.</p> <p>The corrective intervention of ensuring smoke barrier walls are protected to maintain smoke resistance will be accomplished for the safety of all residents.</p> <p>All residents that reside within the facility have the potential to be affected by this deficient practice. The corrections made protect all residents. An audit was</p>	08/15/2013			

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	<p>acknowledged the aforementioned opening in the smoke barrier wall in the mechanical room in the service corridor next to dietary failed to separate the area from other spaces by smoke resistant partitions and doors.</p> <p>3.1-19(b)</p>		<p>completed of all other areas there are smoke barrier walls. Any other areas noted will be corrected and brought into compliance.</p> <p>The area noted on inspection was repaired and sealed with a fire rated caulk to ensure smoke barrier walls are protected to maintain smoke resistance. All Maintenance staff will be educated to follow up on contractors after work is completed to ensure there that the smoke barrier walls have not been compromised while they are working on/near the smoke barrier walls.</p> <p>To ensure the deficient practice does not recur the facility will review Life Safety Code Standards during Quarterly rounds with our Regional Maintenance Supervisor. There will be a Quality Assurance Tool (attachment A) completed. This will be completed by the maintenance supervisor or designee.</p> <p>These systemic changes will be in place by August 15,2013.</p>		

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K010033 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>Based on observation, record review and interview; the facility failed to maintain the vertical opening protection for 2 of 4 exit stairs. LSC 8.2.5.2 requires openings shall be protected as appropriate for the fire resistance rating of the barrier. LSC 7.1.3.2.1(a) requires a one hour rating in existing buildings of three stories or less. This deficient practice could affect 40 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Assistant during a tour of the facility from 12:00 p.m. to 3:40 p.m. on 07/16/13, the stairwell access door on the first floor near the main entrance, on the second floor near the Breakroom and on the second floor near Room 236 each had a label affixed stating the fire resistance rating of each stairwell access door was twenty minutes. Based on interview at the time of the observations, the Maintenance Assistant acknowledged the fire resistance rating of each of the aforementioned stairwell access doors</p>	K010033	<p>K 033 NFPA 101 Life Safety Code Standard</p> <p>The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix K033.</p> <p>The corrective interventions of replacing the door will be accomplished for the safety of all residents.</p> <p>All residents that reside within the facility have the potential to be effected by this deficient practice. The corrections made protect all residents. An audit was completed of all other areas where a door accompanies a stairwell. Any doors found without at least a one hour fire resistance will be brought to code.</p>	08/15/2013	

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	was twenty minutes. 3.1-19(b)		The doors will be replaced with doors that meet the requirement of a fire resistance rating of at least one hour. To ensure the deficient practice does not recur the facility will review Life Safety Code Standards during Quarterly rounds with our Regional Maintenance Supervisor. There will be a Quality Assurance Tool (attachment A) completed. This will be completed by the maintenance supervisor or designee. These systemic changes will be in place by August 15,2013.		

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K010038 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 3 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 62 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Assistant during a tour of the facility from 12:00 p.m. to 3:40 p.m. on 07/16/13, the skilled unit corridor exit by Room 123, by Room 213 and by Room 236 were each marked as a facility exit, each exit door was magnetically locked and could be opened by entering a</p>	K010038	<p>K 038 NFPA 101 Life Safety Code Standard</p> <p>The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix K038.</p> <p>The corrective interventions of posting the four digit code to disable the magnetic lock to ensure that the staff can readily unlock the door at all times will be accomplished for the safety of all residents.</p> <p>All residents that reside within the facility have the potential to be effected by this deficient practice. The corrections made protect all residents. An audit was completed of all other areas where doors are mechanically or otherwise secured. Any doors found without the means to disable will be brought to code.</p>	08/15/2013			

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	<p>four digit code but the code was not posted. Based on interview with the Maintenance Assistant acknowledged the four digit code was not posted at each of the aforementioned facility exits. Based on interview at 2:50 p.m. on 07/16/13, the Administrator stated skilled unit residents do not have a clinical diagnosis to be in a secure building and acknowledged the exit access code should be posted at each facility exit. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.</p> <p>3.1-19(b)</p>		<p>The four digit codes will be posted on the control for magnetic door lock. All staff will be inserviced and instructed that these codes are to remain posted.</p> <p>To ensure the deficient practice does not recur the facility will audit the placement of the code 5x per week for 6 weeks and then will continue by use of the Life Safety Code Standards during Quarterly rounds with our Regional Maintenance Supervisor. There will be a Quality Assurance Tool (attachment A) completed. This will be completed by the maintenance supervisor or designee.</p> <p>These systemic changes will be in place by August 15,2013.</p>	

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K010046 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 2 of 2 battery powered lights for 12 months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hr duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "TELS: Logbook Documentation", with the Maintenance Assistant during record review from 9:10 a.m. to 11:20 a.m. on 07/16/13, the following was noted:</p> <p>a) documentation of an annual ninety minute test for each of two battery operated emergency lights in the facility</p>	K010046	<p>K 046 NFPA 101 Life Safety Code Standard</p> <p>The facility has requested and Informal Dispute Resolution for this deficiency. We are requesting this IDR because the recorded information was not available at the time of the survey to present to the surveyor as proof of completion of the required testing and documentation. The facility is requesting this deficiency be removed from the survey.</p> <p>However, as required, the facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix K046.</p> <p>The corrective interventions will be accomplished for the safety off all residents.</p> <p>All residents that reside within the facility have the potential to be</p>	08/15/2013			

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	<p>within the most recent twelve month period was not available for review.</p> <p>b) functional testing documentation at 30 day intervals for not less than 30 seconds for each of two battery powered emergency lights for the most recent twelve month period was not available for review.</p> <p>Based on interview at the time of record review, the Maintenance Assistant acknowledged monthly and annual testing documentation for each of two battery operated emergency lights was not available for review. Based on observations with the Maintenance Assistant during a tour of the facility from 12:00 p.m. to 3:40 p.m. on 07/16/13, two battery powered emergency lights were observed in the facility at the emergency generator location.</p> <p>3.1-19(b)</p>		<p>affected by this deficient practice. The corrections made protect all residents.</p> <p>We will continue to document testing of emergency lighting of battery powered lights. We will ensure a functional test is conducted every 30 days for more than 30 seconds and annually for more that 1.5 hours. The maintenance staff will be educated on the location of these records for ease of record review at any given time.</p> <p>To ensure the deficient practice does not recur the facility will monitor by use of the Life Safety Code Standards during Quarterly rounds with our Regional Maintenance Supervisor. There will be a Quality Assurance Tool (attachment A) completed. This will be completed by the maintenance supervisor or designee.</p> <p>These systemic changes will be in place by August 15,2013.</p>				

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K010050 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 4 of 4 quarters. This deficient practice affects all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire & Evacuation Drill/Event Form" documentation with the Maintenance Assistant during record review from 9:10 a.m. to 11:20 a.m. on 07/16/13, third shift fire drills conducted on 09/27/12, 12/19/12, 03/27/13 and 06/25/13 were each conducted at 5:30 a.m. Based on interview at the time of record review, the Maintenance Assistant acknowledged third shift fire drills were not conducted at unexpected times under varying conditions.</p>	K010050	<p>K 050 NFPA 101 Life Safety Code Standard</p> <p>The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix K050.</p> <p>The corrective interventions will be accomplished for the safety of all residents.</p> <p>All residents that reside within the facility have the potential to be effected by this deficient practice. The corrections made protect all residents.</p> <p>The maintenance director has</p>	08/15/2013			

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	3.1-19(b)		<p>been inserviced on the importance of having unexpected and varying times on fire drills. A schedule has been created to assist in ensuring these unexpected and varying times occur. This schedule is shared only with the Maintenance Director and the Administrator to ensure it is unexpected and varies. We have attached this schedule for review (Attachment C)</p> <p>To ensure the deficient practice does not recur the facility will monitor by use of the Life Safety Code Standards during Quarterly rounds with our Regional Maintenance Supervisor. There will be a Quality Assurance Tool completed. This will be completed by the maintenance supervisor or designee.</p> <p>These systemic changes will be in place by August 15,2013.</p>		

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K010147 SS=B	<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 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. 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 five staff.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Assistant during a tour of the facility from 12:00 p.m. to 3:40 p.m. on 07/16/13, a refrigerator was observed plugged into a power strip in the Accounts Payable Office on the second floor. In addition, a coffee pot was observed plugged into a second power strip in the Accounts Payable Office on the second floor. Based on interview at the time of the observations, the Maintenance Assistant acknowledged power strips were utilized for a refrigerator and a coffee pot in the Accounts Payable Office on the second floor.</p> <p>3.1-19(b)</p>	K010147	<p>K 147 NFPA 101 Life Safety Code Standard The facility respectfully submits the follow147. The corrective interventions will be accomplished for the safety of all residents. All residents that reside within the facility have the potential to be effected by this deficient practice. The corrections made protect all residents. All staff have been inserviced on NFPA 70, Article 400-8 where it is required, unless specially permitted that flexible cords and cables shall not be used as substitute for fixed wiring. To ensure the deficient practice does not recur the facility will monitor by use of the Life Safety Code Standards during Quarterly rounds with our Regional Maintenance Supervisor. There will be a Quality Assurance Tool (attachment A) completed. This will be completed by the maintenance supervisor or designee. These systemic changes will be in place by August 15,2013.</p>	08/15/2013	

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K019999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(a) The facility must be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel, and the public.</p> <p>This State Rule has not been met as evidenced by: Based on record review and interview, the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 16 of 16 resident sleeping rooms. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Smoke Detector Maintenance Log for 2012 and 2013" documentation with the Maintenance Assistant during record review from 9:10 a.m. to 11:20 a.m. on 07/16/13, an itemized listing of monthly battery operated smoke detector testing for each resident sleeping room location was not available for review. The results of monthly checks of battery operated</p>	K019999	<p>K 9999 NFPA 101 Life Safety Code Standard</p> <p>The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix K9999.</p> <p>The corrective interventions will be accomplished for the safety of all residents.</p> <p>All residents that reside within the facility have the potential to be affected by this deficient practice. The corrections made protect all residents.</p> <p>The Battery Operated Smoke Detector log (Attachment D) is now itemized and includes the specific location of each battery operated Smoke Detector. This itemized list will now be used to show preventive maintenance of each individual battery operated smoke detector within the facility.</p>	08/15/2013			

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	<p>smoke detectors in 64 resident sleeping rooms are documented as "64 = Resident Room" and not itemized by room location on the aforementioned documentation for the period of 08/09/12 through 07/08/13. Based on interview at the time of record review, the Maintenance Assistant acknowledged documentation of the periodic testing and cleaning for battery operated smoke detectors in each resident sleeping room was not available for review.</p> <p>3.1-19(a)</p>		<p>To ensure the deficient practice does not recur the facility will monitor by use of the Life Safety Code Standards during Quarterly rounds with our Regional Maintenance Supervisor. There will be a Quality Assurance Tool (attachment A) completed. This will be completed by the maintenance supervisor or designee.</p> <p>These systemic changes will be in place by August 15,2013.</p>	