

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155428	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/15/2016
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NAME OF PROVIDER OR SUPPLIER MERIDIAN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 S MERIDIAN ST INDIANAPOLIS, IN 46225
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K 0000 Bldg. 01	<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: 04/15/16</p> <p>Facility Number: 000386 Provider Number: 155428 AIM Number: 100286820</p> <p>At this Life Safety Code survey, Meridian Nursing and Rehabilitation Center 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 II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a</p>	K 0000	<p>On April 15, 2016 an inspector from Life Safety completed an annual survey at Meridian Nursing and Rehab. Enclosed please find the statement of deficiencies with the facility's plan of correction for these alleged deficiencies.</p> <p>Please consider this letter and plan of correction to be the facilities credible allegation of compliance. This letter is our request for a desk review to verify the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the plan of correction as of May 15, 2016.</p> <p>Respectfully, Ethan Peak, Administrator</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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K 0017 SS=E Bldg. 01	<p>capacity of 44 and had a census of 34 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached buildings which were each not sprinklered.</p> <p>Quality Review completed on 04/20/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 Based on observation and interview, the facility failed to provide corridor wall separation in 1 of over 20 rooms. This deficient practice could affect 16 residents, staff and visitors in the vicinity</p>	K 0017	<p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: Holes in the Social Service office will</p>	05/15/2016

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	<p>of the Social Services Office.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 11:20 a.m. to 12:20 a.m. on 04/15/16, a three inch hole for the passage of a one inch in diameter water line was noted in the corridor wall above the door to the Social Services Office which was not smoke resistant and failed to separate the room from the corridor. Based on interview at the time of the observation, the Administrator acknowledged the aforementioned hole in the wall failed to separate the Social Services Office from the corridor.</p> <p>3.1-19(b)</p>		<p>be filled with proper fire rating caulk by 5/15/16.</p> <p>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:</p> <p>This has the potential to affect up to 16 residents whose rooms are in the same corridor.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Once completed weekly rounds will be conducted by the Maintenance director/designee for 4 weeks to identify any holes and ensure the caulking material is in place, and then monthly for 3 months to ensure any holes are filled with appropriate smoke resistant material. Maintenance director/designee will follow behind any contractor to ensure new holes are filled properly.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Results will be brought to QA for follow up and review for 3 months, or until 100% compliance is achieved.</p>	

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K 0018 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of over 20 corridor doors would resist the passage of smoke. This deficient practice could affect 16 residents, staff and visitors in the vicinity of the Boiler Room by the Pump Room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance</p>	K 0018	<p>By what date the systemic changes will be completed: 5/15/16</p> <p>What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The self-closing device will be fixed and the holes in the boiler room door will be corrected by 5/15/16.</p> <p>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: This has the potential to affect up to</p>	05/15/2016

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K 0025 SS=F Bldg. 01	<p>Director during a tour of the facility from 11:20 a.m. to 12:20 a.m. on 04/15/16, two separate three quarter inch in diameter holes were noted in the corridor door to the Boiler Room which contained an electric furnace. The holes were located where a self-closing device for the door had become loose and was not properly affixed to the door. Based on interview at the time of observation, the Administrator and the Maintenance Director acknowledged the aforementioned corridor door would not resist the passage of smoke.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the</p>	K 0025	<p>16 residents whoserooms are in the same corridor.</p> <p>What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur: Once completed weekly rounds will be conducted by the Maintenancedirector/designee for 4 weeks and then monthly for 3 months to ensure concernsare corrected.</p> <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place: Results will be brought to QA for follow up and reviewfor 3 months, or until 100% compliance is achieved.</p> <p>By what date thesystemic changes will be completed: 5/15/16</p> <p>What Correctiveaction(s) will be</p>	05/15/2016	

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	<p>facility failed to ensure openings through 1 of 10 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 11:20 a.m. to 12:20 a.m. on 04/15/16, a two inch in diameter hole for the passage of two cables was noted in the west side of the smoke barrier wall above the corridor door set by Room 4. The aforementioned hole was also noted on the east side of the smoke barrier wall above the suspended ceiling and was not filled with a material capable of maintaining the smoke resistance of the smoke barrier. Based on interview at the time of observation, the Maintenance Director acknowledged the opening in the aforementioned smoke barrier wall was not filled with a material to maintain the</p>		<p>accomplished for those residents found to have been affected by the deficient practice: Holes above the drop ceiling for new cables will be filled and sealed with appropriate fire-rated caulking.</p> <p>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: This has the potential to affect up to 16 residents whose rooms are in the same corridor.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Once completed weekly rounds will be conducted by the Maintenance director/designee for 4 weeks to identify any holes and ensure the caulking material is in place, and then monthly for 3 months to ensure any holes are filled with appropriate smoke resistant material.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Results will be brought to QA for follow up and review for 3 months, or until 100% compliance is achieved.</p>	

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K 0029 SS=E Bldg. 01	<p>fire resistance rating of the smoke barrier wall.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 areas such as fuel fired heater rooms and central/bulk laundries greater than 100 square feet in size were separated from other areas by smoke resistant partitions. This deficient practice could affect 16 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 11:20 a.m. to 12:20 a.m. on 04/15/16, the following was noted:</p> <p>a. a five inch in diameter hole for the passage of three pipes and a water line</p>	K 0029	<p>By what date the systemic changes will be completed: 5/15/16</p> <p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: Holes will be filled in the maintenance room, mainmechanical room and laundry room with appropriate fire rated caulking by5/15/16.</p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken: This has the potential to affect up to 16 residents whoserooms are in the same corridor.</p> <p>What measures willbe put into place or what systemic changes will</p>	05/15/2016

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K 0050 SS=C Bldg. 01	<p>and a six inch in diameter hole for the passage of one water line was noted near the ceiling in the north wall of the Main Mechanical Room which contained two natural gas fired water heaters. In addition, an eight inch in diameter hole was also noted in the north wall of the Main Mechanical Room near the floor behind the water heaters.</p> <p>b. a four inch in diameter hole was noted in the corridor wall above the corridor door to the soiled side of the Laundry. Based on interview at the time of the observations, the Administrator acknowledged the aforementioned openings in the Main Mechanical Room and the Laundry did not separate these hazardous areas from other spaces by smoke resistant partitions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms.</p>		<p>be made to ensure that thedeficient practice does not recur: Once completed weekly rounds will be conducted by theMaintenance director/designee for 4 weeks to identify any holes and ensure thecaulking material is in place, and then monthly for 3 months to ensure anyholes are filled with appropriate smoke resistant material.</p> <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place: Results will be brought to QA for follow up and reviewfor 3 months, or until 100% compliance is achieved.</p> <p>By what date thesystemic changes will be completed: 5/15/16</p>	

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K 0062 SS=D Bldg. 01	<p>18.7.1.2, 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 second shift for 3 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" and "Monthly Fire Drill" documentation with the Administrator and Maintenance Director during record review from 9:05 a.m. to 11:20 a.m. on 04/15/16, second shift (3:00 p.m. to 11:00 p.m.) fire drills conducted on 05/28/15, 08/31/15 and 11/24/15 were conducted at, respectively, 3:11 p.m., 3:11 p.m. and 3:21 p.m. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned second shift fire drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating</p>	K 0050	<p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: Fire drills will be held at unexpected times varying intime and conditions for all 3 shifts.</p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken: This has the potential to affect all residents. What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur: Monthly fire drills will be held at varying times with atleast a 2 hour difference between each fire drill. Quarterly audit sheet will be used to ensurevarying times across all shifts. How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place: Results will be brought to QA for follow up and reviewfor 3 months, or until 100% compliance is achieved. By what date thesystemic changes will be completed: 5/15/16</p>	05/15/2016	

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	<p>condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace 1 of over 50 sprinklers which had become corroded, had paint, lint or other foreign materials on them. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect two staff and visitors in the Laundry.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 11:20 a.m. to 12:20 a.m. on 04/15/16, the pendent sprinkler installed behind the dryers in the Laundry was covered with lint. Based on interview at the time of observation, the Administrator acknowledged the aforementioned sprinkler location had foreign materials attached to it.</p>	K 0062	<p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:</p> <p>The sprinkler in laundry which was identified to have lint will be corrected by 5/15/16.</p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:</p> <p>This has the potential to affect all residents.</p> <p>What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:</p> <p>Weekly audit of sprinklers will be conducted for 4 weeksand then monthly for 3 months to ensure sprinklers are kept free of debris anddamage.</p> <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:</p> <p>Results and schedule will be brought to QA for follow upand review for 3 months, or until 100% compliance is achieved.</p>	05/15/2016

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K 0144 SS=F Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 10 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as</p>	K 0144	<p>By what date the systemic changes will be completed: 5/15/16</p> <p>What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Monthly load tests will be conducted and documented with percent of load.</p> <p>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: This has the potential to affect all residents.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A 30 minute load test will be conducted monthly and documented by maintenance/designee. After each monthly test, results will be audited by administrator to ensure compliance for 3 months.</p> <p>How the corrective action(s) will be</p>	05/15/2016

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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
	<p>recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. 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, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Weekly Generator System Service & Testing" documentation with the Administrator and Maintenance Director during record review from 9:05 a.m. to 11:20 a.m. on 04/15/16, documentation of monthly load testing for April 2015 through September 2015 and November 2015 through February 2016 did not indicate a load test was conducted. The aforementioned documentation was left blank as the response to "% of Load" and "Load Test." Based on interview at the time of record review, the Maintenance Director stated the emergency generator is started on a weekly basis but acknowledged load testing documentation for the aforementioned ten month period did not state a load test was conducted.</p>		<p>monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Results and schedule will be brought to QA for follow up and review for 3 months, or until 100% compliance is achieved.</p> <p>By what date the systemic changes will be completed: 5/15/16</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155428	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/15/2016
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K 0154 SS=C Bldg. 01	<p>3.1-19(b)</p> <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 34 of 34 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(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 "Fire Watch" and "Plant Operations: Fire Watch"</p>	K 0154	<p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: Fire watch policy is to be reviewed and updated asapropriate.</p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken: This has the potential to affect all residents.</p> <p>What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur: Fire watch policy is to be reviewed and updated asapropriate by 5/15/16. Staff will bein-serviced on the fire watch policy the week of 5/8/16.</p> <p>How the correctiveaction(s) will be</p>	05/15/2016

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K 0155 SS=C Bldg. 01	<p>documentation with the Administrator and Maintenance Director during record review from 9:05 a.m. to 11:20 a.m. on 04/15/16, the written fire watch policy for the facility in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period did not include notification of the Indiana State Department of Health (ISDH) which is the authority having jurisdiction, the fire alarm system monitoring company, the insurance carrier and the building owner. The aforementioned fire watch policies stated to contact the "local fire department" and the "state licensing agency" only. Based on interview at the time of record review, the Maintenance Director acknowledged the written fire watch policy for the facility in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period did not include notification of ISDH, the fire alarm system monitoring company, the insurance carrier and the building owner.</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</p>		<p>monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator/designee will ensure proper notification at the time a Fire Watch is put into place.</p> <p>By what date the systemic changes will be completed: 5/15/16</p>	

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	<p>approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 in order to protect 34 of 34 residents. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Watch" and "Plant Operations: Fire Watch" documentation with the Administrator and Maintenance Director during record review from 9:05 a.m. to 11:20 a.m. on 04/15/16, the written fire watch policy for the facility in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period did not include notification of the Indiana State Department of Health (ISDH) which is an authority having jurisdiction. The aforementioned fire watch policies stated to contact the "state licensing agency." Based on interview at the time of record review, the Maintenance Director acknowledged the written fire watch policy for the facility in the event</p>	K 0155	<p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: Fire watch policy is to be reviewed and updated asapropriate.</p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken: This has the potential to affect all residents.</p> <p>What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur: Fire watch policy is to be reviewed and updated asapropriate by 5/15/16. Staff will bein-serviced on the fire watch policy the week of 5/8/16.</p> <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place: Administrator/designee will ensure proper notification atthe time a Fire Watch is put into place.</p> <p>By what date thesystemic changes</p>	05/15/2016

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	the fire alarm system has to be placed out of service for four hours or more in a 24 hour period did not include notification of ISDH. 3.1-19(b)		will be completed: 5/15/16		