

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155761	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/27/2015
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NAME OF PROVIDER OR SUPPLIER BROWNSBURG MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2 E TILDEN BROWNSBURG, IN 46112
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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: 10/27/15</p> <p>Facility Number: 011367 Provider Number: 155761 AIM Number: 200851590</p> <p>At this Life Safety Code survey, Brownsburg Meadows 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 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 147</p>	K 0000	<p>The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEY REVIEW</p>	

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 0027 SS=E Bldg. 01	<p>and a census of 121.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed 10/29/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8</p> <p>Based on observation and interview, the facility failed to ensure 6 of 10 sets of smoke barrier doors would close to form a smoke resistant barrier. This deficient practice could affect 75 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Administrator in Training (AIT) and the Maintenance Director during a tour of the</p>	K 0027	<p>K 0027 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Astragals have been installed at the 6 sets of smoke barrier doors that did not have them 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by this practice.</p>	11/26/2015

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K 0029 SS=E Bldg. 01	<p>facility from 11:25 a.m. to 1:45 p.m. on 10/27/15, the following sets of smoke barrier corridor doors which each swing in the opposite direction were not equipped with an astragal, rabbet or bevel at the meeting edge:</p> <p>a. Auguste's Dining Room. b. the west corridor door set in the Main Dining Room. c. by Room 427. d. 200 Hall Dining Room door set leading to the service hall. e. by Room 301. f. in the 400 Hall.</p> <p>Based on interview at the time of the observations, the AIT and the Maintenance Director acknowledged the aforementioned smoke barrier door sets each swing in the opposite direction and are not equipped with an astragal, rabbet or bevel at the meeting edge.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the</p>	K 0029	<p>The Maintenance Director will ensure that any new set of smoke barrier doors will be equipped with astragals upon installation</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director will ensure that any new set of smoke barrier doors will be equipped with astragals upon installation</p> <p>4. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? Audits for astragal placement will be conducted by the Maintenance Director/ designee quarterly for at least 2 consecutive quarters until 100% compliance is achieved Results to be reviewed quarterly in QA meeting overseen by the ED</p> <p>K 0029 1. What corrective actions will be accomplished</p>	11/26/2015	

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	<p>facility failed to ensure 1 of 12 hazardous areas such as storage rooms greater than 100 square feet in size and used to store combustible material were enclosed with a one hour fire rated barrier with a 45 minute fire rated door. Table 18.3.2.1 Hazardous Area Protection requires storage rooms larger than 100 square feet storing combustible material to be provided with 1 hour separation/protection. Doors to hazardous areas are self closing or close automatically upon activation of the fire alarm system. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the former Wellness Center.</p> <p>Findings include:</p> <p>Based on observation with the Administrator in Training (AIT) and the Maintenance Director during a tour of the facility from 11:25 a.m. to 1:45 p.m. on 10/27/15, the corridor door to the former Wellness Center was not equipped with a self closing device and had no affixed fire resistance label stating a minimum 45 minute fire resistance rating. The former Wellness Center measured 300 square feet in size and was used to store beds, desks, chairs, mattresses and boxes from wall to wall. Based on interview at the time of observation, the AIT and</p>		<p>for those residents found to have been affected by the deficient practice? The identified room is no longer being used as a room to store combustible material and no longer requires a fire rated door 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents had the potential to be affected by this practice and the identified room is no longer being used for storage 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director will oversee that no other room greater than 100 square feet gets converted to a storage room without having a properly rated fire door 4. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? Audits will be conducted of the facility by the Maintenance Director/ designee to ensure no room greater than 100 square feet is converted to a storage room monthly for the next 3 months then quarterly for at</p>	

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K 0038 SS=E Bldg. 01	<p>Maintenance Director stated they were unaware of the fire resistance rating of the aforementioned corridor door and acknowledged the entry door from the corridor was not provided with a self closing device and was not at least a 45 minute fire rated door.</p> <p>3.1-19(b)</p> <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. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 exits were readily accessible for residents, staff and visitors. LSC 18.2.2.2.4 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 16 residents, staff and visitors if needing to exit the building using Exit 6 in the</p>	K 0038	<p>least 2 quarters until 100% compliance is achieved Results to be reviewed quarterly at the QA meeting overseen by the ED.</p> <p>K 0038 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Vanguard came out immediately upon being called to reset the code on door at Exit 6 to match the security codes on the other 2 internal Auguste's Cottage doors 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents residing on Auguste's Cottage have the potential to be affected by this practice. The Maintenance Director will ensure that the code is changed to match all locked units of the facility 3. What measures will be put into place or what systemic</p>	11/26/2015			

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K 0046 SS=F Bldg. 01	<p>Alzheimer's wing.</p> <p>Findings include:</p> <p>Based on observation with the Administrator in Training (AIT) and the Maintenance Director during a tour of the facility from 11:25 a.m. to 1:45 p.m. on 10/27/15, Exit 6 to the exterior of the building from the Alzheimer's wing was marked as a facility exit, the exit door was magnetically locked and could be opened by entering a four digit code but the magnetic lock would not release the door to open when the four digit code was entered five separate times. Based on interview at the time of observation, the AIT stated the code to release the door was not posted at the exit because of the clinical needs of the Alzheimer's wing residents, an alternate code to release the door was not known and acknowledged the four digit code entered to release the door did not unlock the door.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1</p> <p>1. Based on record review, observation, and interview; the facility failed to document testing of emergency lighting</p>	K 0046	<p>changes will be made to ensure that the deficient practice does not recur? The Maintenance Director will ensure that the code is changed to match all locked units of the facility 4. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? Audits of all the locked unit codes will be conducted by the Maintenance Director/ designee weekly for 4 weeks, monthly for 2 months then quarterly for at least 2 quarters until 100% compliance is achieved Results will be reviewed quarterly in the QA meeting overseen by the ED</p> <p>K 0046 1. What corrective actions will be accomplished for those residents found to have been affected by the</p>	11/26/2015			

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	<p>in accordance with LSC 7.9 for 30 of 30 battery operated emergency lights. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals 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 "Battery Operated Emergency Lights-Test Log for Year 2014 and 2015" documentation with the Administrator in Training (AIT) and the Maintenance Director during record review from 9:30 a.m. to 11:25 a.m. on 10/27/15, the facility has thirty battery operated lights located in the facility. The most recent documented annual functional testing of facility battery operated emergency lights was on 06/12/14 which was greater than twelve months. Based on observations with the AIT and the Maintenance Director during a tour of the facility from 11:25 a.m. to</p>		<p>deficient practice? 1. The Maintenance Director performed the monthly functional testing on all 30 batteries on 10/28/15 and changed the battery on the battery-operated emergency light located in the mechanical room housing the generator transfer switch 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by this practice.</p> <p>The Maintenance Director will check all battery-operated lights monthly at 30 day intervals and change batteries as needed and Vanguard will perform and document annual testing of at least 60 minute burn time on all battery-operated lights The Maintenance Director will check the battery-operated light in the mechanical room monthly at 30 day intervals and will change battery as needed 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director will check all battery-operated lights monthly at 30 day intervals and change batteries as needed and Vanguard will perform and document annual</p>				

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	<p>1:45 p.m. on 10/27/15, thirty battery operated lighting systems were observed in the facility and each light which was tested functioned when its respective test button was pushed except for the light located at the emergency transfer switch location. Based on interview at the time of record review and of the observations, the Maintenance Director acknowledged annual functional testing documentation for all battery operated emergency lights in the facility within the most recent twelve month period was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 30 battery operated emergency lights was maintained in accordance with LSC 7.9. LSC 7.9.2.4 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p>		<p>testing of at least 60 minute burn time on all battery-operated lights The Maintenance Director will check the battery-operated light in the mechanical room monthly at 30 day intervals and will change battery as needed</p> <p>4. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? Audits will be conducted by the Maintenance Director/ designee monthly for at 3 months then quarterly for at least 2 quarters until 100% compliance is achieved, Results to be reviewed at quarterly QA meeting overseen by the ED.</p>	

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K 0062 SS=F Bldg. 01	<p>Based on observation with the Maintenance Director at 1:45 p.m. on 10/27/15, the battery powered emergency light located in the Mechanical Room housing the emergency generator transfer switch failed to illuminate when its respective test button was pressed five times. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned battery operated emergency light failed to illuminate when its respective test button was pressed five times.</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. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review, observation and interview; the facility failed to document weekly fire pump inspection, testing and maintenance for 1 of 1 fire pumps for 51 of 52 weeks during the most recent twelve month period. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code to be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly</p>	K 0062	<p>K 0062 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Dalmation Fire came out on to facility to further educate facility Maintenance Director on weekly fire pump testing, inspecting and maintenance Dalmation Fire retested all 4 hydrants on 10/28/15 and identified each hydrant by location in the</p>	11/26/2015

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	<p>maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition. NFPA 25, Chapter 5-1.1 provides the minimum requirements for the routine inspection, testing, and maintenance of fire pump assemblies. Table 5-1.1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Chapter 5-3.2.1 requires a weekly test of electric motor-driven pump assemblies shall be conducted without flowing water. This test shall be conducted by starting the pump automatically. The pump shall run a minimum of 10 minutes.</p> <p>Exception: A valve installed to open as a safety feature shall be permitted to discharge water.</p> <p>5-3.2.2.1. The automatic weekly test timer shall be permitted to be substituted for the starting procedure. The pertinent visual observations specified in Chapters 5-2.2.1, through Chapter 5-2.2.3 shall be performed weekly. Chapter 1-8 states records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility.</p>		<p>report Escutcheons have been replace on the 3 identified sprinkler heads found to not have them in place</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by this practice</p> <p>The Maintenance Director will perform weekly fire pump inspecting, testing and maintenance and document findings in a log</p> <p>Dalmation Fire will perform annual hydrant testing and will properly identify location of all 4 hydrants tested</p> <p>The Maintenance Director will audit for any loose or missing escutcheon plates on sprinkler heads and replace as needed</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director will perform weekly fire pump inspecting, testing and maintenance and document findings in a log</p> <p>Dalmation Fire will perform annual hydrant testing and will properly identify location of all 4 hydrants tested</p> <p>The Maintenance Director will audit for any loose or missing</p>	

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	<p>Findings include:</p> <p>Based on record review with the Administrator in Training (AIT) and the Maintenance Director from 9:30 a.m. to 11:25 a.m. on 10/27/15, documentation of weekly fire pump inspection, testing and maintenance for 51 of 52 weeks during the most recent twelve month period was not available for review. An annual test of the electric motor-driven pump assembly was conducted as documented in Vanguard Alarm Service's 09/15/15 "Fire Pump Test Data Sheet" inspection documentation but no additional fire pump inspection, testing and maintenance was available for review. Based on interview at the time of record review, the Maintenance Director stated he was unaware weekly fire pump inspection, testing and maintenance was required and acknowledged documentation of weekly fire pump inspection, testing and maintenance for 51 of 52 weeks during the most recent twelve month period was not available for review. Based on observation with the Maintenance Director at 1:45 p.m. on 10/27/15, an operable electric motor-driven fire pump assembly was noted in the mechanical room containing the facility's automatic sprinkler system riser.</p>		<p>escutcheon plates on sprinkler heads and replace as needed</p> <p>4. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? Audits of weekly fire pump inspecting (testing/maintenance) and escutcheon plates will be conducted by the Maintenance Director/ designee monthly for 3 months then quarterly for at least 2 quarters until 100% compliance is achieved Results of findings will be reviewed quarterly in QA meeting overseen by the ED</p>	

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	<p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 4 of 4 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Dalmatian Fire Inc. "Fire Hydrant Inspection Form" dated 09/08/15 with the Administrator in Training (AIT) and the Maintenance Director during record review from 9:30 a.m. to 11:25 a.m. on 10/27/15, documentation of facility fire hydrant inspections within the most recent twelve month period stated all fire hydrants were tested but did not state the location and results of testing for each facility fire hydrant. In addition, review of P.I.P.E's "Hydrant Flow Test Report" inspection</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155761	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/27/2015
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NAME OF PROVIDER OR SUPPLIER BROWNSBURG MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2 E TILDEN BROWNSBURG, IN 46112
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	<p>conducted prior to October 2014 stated the facility had a total of four fire hydrants. Based on observations with the AIT and the Maintenance Director during a tour of the facility from 11:25 a.m. to 1:45 p.m. on 10/27/15, one fire hydrant was noted near the main entrance parking lot and one fire hydrant was noted at the north road outside the 300 Hall. Based on interview at the time of observation, the AIT and the Maintenance Director acknowledged documentation of facility fire hydrant inspection within the most recent twelve month period did not state the location and results of testing for each facility fire hydrant.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 3 of over 100 sprinkler heads was maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect 30 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Administrator in Training (AIT) and the</p>			

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K 0067 SS=F Bldg. 01	<p>Maintenance Director during a tour of the facility from 11:25 a.m. to 1:45 p.m. on 10/27/15, the escutcheon plate was missing for the automatic sprinkler located on the ceiling at the aforementioned locations:</p> <p>a. in the restroom for Room 107. b. in the restroom at the 400 Hall nurse's station. c. in the 500 Hall Mechanical Room.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged an escutcheon for the aforementioned automatic sprinkler locations was missing.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A</p> <p>Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation</p>	K 0067	<p>K 0067 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Vanguard is scheduled to come to facility to conduct an inspection on all fire dampers on 11/23/15 and 11/24/15</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</p>	11/26/2015

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	<p>of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Administrator in Training (AIT) and the Maintenance Director during record review from 9:30 a.m. to 11:25 a.m. on 10/27/15, documentation of fire damper inspection and maintenance within the most recent four year period was not available for review. Based on observations with the AIT and the Maintenance Director during a tour of the facility from 11:25 a.m. to 1:45 p.m. on 10/27/15, two fire dampers were located in HVAC system ductwork in the Mechanical Room by the west nurses station and in the Therapy Room mechanical room. Based on interview at the time of record review and of the observations, the AIT and the Maintenance Director acknowledged documentation of the necessary</p>		<p>actions will be taken? All residents have the potential to be affected by this practice</p> <p>The Maintenance Director will maintain record of fire damper inspection and assure another inspection will performed timely in 4 years</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The current fire damper inspection report will be kept in the preventative maintenance binder until the next inspection is completed in 4 years</p> <p>4. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?</p> <p>The current fire damper inspection report will be kept in the preventative maintenance binder until the next inspection is completed in 4 years</p>	

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	<p>maintenance and inspection for fire dampers in the facility within the most recent four year period was not available for review.</p> <p>3.1-19(b)</p>				