

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155120	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/10/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRANDYWINE	STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/10/14</p> <p>Facility Number: 000050 Provider Number: 155120 AIM Number: 100266170</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Brandywine 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 (111) construction and fully sprinklered, except for the AACU Shower Room closet. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to</p>	K010000	All of our correctios have been made. We are requesting a desk review of this plan of correction and find us in substantial compliance from this submission.	

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>the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 128 and had a census of 120 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached shed and one garage each providing facility storage services which are not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/17/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 3 of over 75 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing and latching, and would resist the passage of smoke. This deficient practice could affect 60 residents, staff and visitors in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 2:30 p.m. on 03/10/14, the following was noted: a. the Main Dining Room is open to the corridor. The door set from the Main Dining Room into the kitchen was not</p>	K010018	<p>To accomplish corrective actions for residents affected by the practice the identified doors were closed immediately</p> <p>To identify other residents having the potential to be affected by the practice all doors have been inspected to ensure that there are no other doors that are not closing.</p> <p>To ensure that the practice does not recur, the door to the main dining room has been replaced and equipped with a positive latching device. The box was removed to prevent propping of the medical storage door. Maintenance will be including inspection of the storage room doors for proper closing on their preventive maintenance program. This was done on March 14, 2014.</p>	03/24/2014
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	<p>equipped with a positive latching device. The north door in the aforementioned door set was propped open with a wedge and had a four inch long by three inch high hole in the door next to the bottom hinge. In addition, a gap greater than one half inch was noted between the top of the door set and the frame.</p> <p>b. the corridor door to the Medical Supplies storage room was propped in the fully open position with a box. Based on interview at the time of observation, the Maintenance Director acknowledged the corridor door to the Medical Supplies storage room was propped in the fully open position, the corridor door set to the kitchen was propped in the fully open position with a wedge, was not equipped with a positive latching mechanism to latch each door into the door frame and would fail to resist the passage of smoke.</p> <p>3.1-19(b)</p>		<p>To monitor the changes in practice and ensure that the practice does not recur, the maintenance director and the maintenance workers are inspecting the door daily for 14 days, weekly for 4 weeks and then per Preventive Maintenance schedule. Any non compliance will be addressed immediately; reported to the safety committee and the QAPI to determine the need for further action.</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 1 of 1 ceiling smoke barriers was protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect all residents, staff and visitors if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p>	K010025	<p>To accomplish corrective actions for residents affected by the practice the openings in Room 8, 19, 45, 50, the business office, Medical Supply Room, Maintenance office, Wheel Chair Room, and Kitchen Janitor Closet were closed and caulked with fire proof caulk.</p> <p>To identify other residents having the potential to be affected by the practice, the maintenance supervisor inspected all ceilings in the entire building. Any openings identified were sealed and caulked.</p> <p>To ensure that the practice does not recur, all construction work will be monitored and inspected by the maintenance supervisor to ensure that openings created have been properly filled and caulked.</p>	03/24/2014
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	<p>Based on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 2:30 p.m. on 03/10/14, the following openings were noted in the ceiling smoke barrier:</p> <p>a. a one inch in diameter hole in the ceiling of the closets in Room 8, Room 19, Room 45 and Room 50, and a one half inch hole in the ceiling of the Business Office closet. The closet to Room 8 had an additional one half inch in diameter hole.</p> <p>b. a mop head was placed in a six inch by four inch hole of the ceiling in the Medical Supplies Room where a low point drain for the sprinkler system penetrated the ceiling.</p> <p>c. the annular space surrounding seven penetrations by pipes and conduits of the Maintenance Office ceiling were not firestopped. In addition, the annular space surrounding an additional ten conduits penetrating the ceiling were filled with foam which is not an approved material for maintaining the smoke resistance of a smoke barrier.</p> <p>d. a four inch square hole surrounding the penetration of the sprinkler riser into the ceiling of the riser room was not firestopped.</p> <p>e. the Wheelchair closet by Room 7 had a four inch long by one inch wide hole in the ceiling for the passage of 20 telephone cables which was not</p>		<p>To monitor the changes in practice and ensure that the practice does not recur, presence of unsealed ceiling openings will be included on the Preventive Maintenance portion of the building inspections. Any openings identified will be brought to the attention of the safety committee for review of system failure.</p>	

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K010029 SS=E	<p>firestopped. f. the annular space surrounding each of two one inch in diameter water lines penetrating the ceiling of the Janitor's closet in the kitchen was not firestopped. Based on interview at the time of the observations, the Maintenance Director acknowledged each of the aforementioned openings failed to maintain the smoke resistance of the ceiling smoke barrier.</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 Based on observation and interview, the</p>	K010029	To accomplish corrective actions for residents affected by the practice the	03/24/2014			

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	<p>facility failed to ensure 2 of 13 hazardous areas such as combustibile storage rooms over 50 square feet in size and fuel fired heater rooms were separated from other areas by smoke resistant partitions. This deficient practice could affect 60 residents, staff and visitors in the vicinity of the Medical Supplies storage room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 2:30 p.m. on 03/10/14, the following was noted:</p> <p>a. the Medical Supplies storage room measured over 100 square feet in size, was used to store boxes of combustibile supplies and the corridor door was propped in the fully open position with a box. In addition, a mop head was placed in a six inch by four inch hole in the ceiling of the Medical Supplies Room where a low point drain for the sprinkler system penetrated the ceiling.</p> <p>b. The Maintenance Office contained one natural gas fired water heater and the annular space surrounding seven penetrations of the ceiling by pipes and conduits were not firestopped. In addition, the annular space surrounding an additional ten conduits penetrating the ceiling were filled with foam which</p>		<p>door to the Medical Storage was closed immediately. The ceiling openings were sealed and caulked with fire rated caulk.</p> <p>To identify other residents having the potential to be affected by the practice all of the hazardous areas were inspected and no additional areas exist.</p> <p>To ensure that the practice does not recur, maintenance will be including inspection of the storage room doors for proper door closing and ceiling openings on their preventive maintenance program. This was initiated on March 14, 2014.</p> <p>To monitor the changes in practice and ensure that the deficient practice does not recur, , the maintenance director and the maintenance workers are inspecting the door daily for 14 days, weekly for 4 weeks and then the doors and ceilings per Preventive Maintenance schedule. Any non compliance will be addressed immediately; reported to the safety committee and the QAPI to determine the need for further action.</p>				

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K010048 SS=C	<p>is not an approved material for maintaining the smoke resistance of a smoke barrier.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned openings in the ceiling 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 There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>1. Based on record review, observation and interview; the facility failed to develop a written fire safety plan for staff response to the activation of battery operated smoke detectors installed in 65 of 65 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <p>(1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire</p>	K010048	<p>To accomplish corrective actions for residents affected by the practice, the written fire plan was updated to include staff response to battery powered smoke detectors and the use of K fire extinguishers only after the suppression system is activated.</p> <p>To identify other residents having the potential to be affected by the practice there is only one written fire plan.</p> <p>To ensure that the practice does not recur, the Executive Director will review life safety codes for any additions required to the written fire</p>	03/24/2014

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	<p>(5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Action Plan: Fire" documentation with the Maintenance Director during record review from 9:30 a.m. to 11:50 a.m. on 03/10/14, the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms. Based on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 2:30 p.m. on 03/10/14, battery operated smoke detectors are installed in each resident sleeping room. Based on interview at the time of record review, the Maintenance Director acknowledged the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms.</p> <p>3.1-19(a)</p> <p>2. Based on record review, observation</p>		<p>plan and make appropriate corrections as required.</p> <p>To monitor the changes in practice and ensure that the deficient practice does not recur, the written fire plan will be reviewed by the Safety Committee annually and report to the QAPI committee as indicated.</p>				

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	<p>and interview; the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect five kitchen staff.</p> <p>Findings include:</p> <p>Based on review of "Emergency Action Plan: Fire" documentation with the Maintenance Director during record review from 9:30 a.m. to 11:50 a.m. on 03/10/14, the fire disaster plan did not address the use of the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 2:30 p.m. on</p>						

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	<p>03/10/14, a K-class fire extinguisher was located in the kitchen. Based on interview at the time of record review, the Maintenance Director acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using the K-class fire extinguisher.</p> <p>3.1-19(a)</p>			

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K010051 SS=E	<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 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 1 of 47 smoke detectors installed on a ceiling were located not less than four inches from a sidewall. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.4.3 requires spot-type smoke detectors shall be located on the ceiling not less than four inches (100 mm) from a sidewall to the near edge or, if on a sidewall, between 4 inches and 12 inches (100 mm and 300 mm) down from the ceiling to the top of the detector. This deficient practice could affect 60 residents, staff and visitors in the vicinity of the corridor smoke barrier</p>	K010051	<p>To accomplish corrective actions for residents affected by the practice the identified hard wired smoke detector was moved away from the wall to exceed the minimum distance of 4 inches.</p> <p>To identify other residents having the potential to be affected by the practice there are no other detectors closer than 4 inches from a side wall.</p> <p>To ensure that the practice does not recur, if any new smoke detectors are installed, the maintenance supervisor will ensure that placement meets the required clearances from side walls and ceilings.</p>	03/24/2014

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	<p>door set by Room 15.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 2:30 p.m. on 03/10/14, a smoke detector hard wired to the fire alarm system was installed on the ceiling above the corridor smoke barrier door set by Room 15 and was located two inches from the sidewall of the adjoining corridor. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned smoke detector was installed on the ceiling less than four inches from the sidewall of the adjoining corridor.</p> <p>3-1.19(b)</p>		To monitor the changes in practice and ensure that the practice does not recur, any new installations will be approved only when the required distances from the side wall or ceiling are written into the scope of work.		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRANDYWINE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140			
(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			
K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure a sprinkler was installed in 1 of 4 shower room closets to provide coverage for all portions of the building. This deficient practice could affect 12 residents, staff and visitors in the vicinity of the AACU Shower Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 2:30 p.m. on 03/10/14, the closet in the AACU Shower Room was not sprinklered.</p> <p>Based on interview at the time of observation, the Maintenance Director stated the AACU Shower Room was recently remodeled and acknowledged</p>	K010056	<p>To accomplish corrective actions for residents affected by the practice a sprinkler was installed on 03/14/2014 in the newly constructed closet in the AACU shower room.</p> <p>To identify other residents having the potential to be affected by the practice there are no other closets that lack sprinklers.</p> <p>To ensure that the practice does not recur, the maintenance supervisor will insure that any new construction will be complete after the installation of an required sprinkler is completed.</p> <p>To monitor the changes in practice and ensure that the practice does not recur, any new installations will be approved only when the required sprinklers are written into the scope of work.</p>	03/24/2014			

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K010062 SS=E	<p>the aforementioned closet was not sprinklered.</p> <p>3.1-19(b) 3.1-19(ff)</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> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.1 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This</p>	K010062	<p>To accomplish corrective actions for residents affected by the practice the boxes were removed in the supply closet, the napkins and boxes were removed from the supply closet by the back entrance, and the tubs were removed in the shower storage room.</p> <p>To identify other residents having the potential to be affected by the practice there are no other storage areas to inspect.</p> <p>To ensure that the practice does not recur, the maintenance supervisor will ensure that storage areas are inspected with the preventive maintenance program. All managers were re-educated that storage cannot obstruct the sprinkler spray pattern.</p>	03/24/2014			

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	<p>deficient practice could affect 60 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 2:30 p.m. on 03/10/14, the following was noted:</p> <p>a. boxes were stored on a shelf six inches directly under a pendent sprinkler in the supply closet by Room 45.</p> <p>b. packages of napkins and boxes were stored on shelves within two inches of the ceiling in the Medical Supplies storage room.</p> <p>c. plastic tubs were stored on a shelf within six inches of the ceiling in the AACU Shower Room storage room.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned storage locations provided obstructions to the sprinkler system spray pattern.</p> <p>3.1-19(b)</p>		<p>This education was conducted by the Executive Director on March 14, 2014.</p> <p>To monitor the changes in practice and ensure that the practice does not recur, maintenance supervisor will correct and report any non compliance noted during inspections at the safety committee monthly meetings. The QAPI members will receive a monthly report from the safety committee including any life safety issues identified preventive maintenance inspections.</p>	

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K010130 SS=C	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 65 of 65 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. 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" documentation with the Maintenance Director during record review from 9:30 a.m. to 11:50 a.m. on 03/10/14, documentation of battery operated smoke detector cleaning within the most recent twelve month period was not available for review. The aforementioned maintenance log documented testing for the twelve month period of 03/06/13 through 02/12/14 but did not document any periodic cleaning. Based on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 2:30 p.m. on</p>	K010130	<p>To accomplish corrective actions for residents affected by the practice all battery powered smoke detectors were re-inspected, re-cleaned and documented to include tested and cleaned on the log sheet.</p> <p>To identify other residents having the potential to be affected by the practice there are no other log sheets needing to be updated.</p> <p>To ensure that the practice does not recur, the maintenance supervisor will ensure that the log sheet is properly documented each month.</p> <p>To monitor the changes in practice and ensure that the deficient practice does not recur, the log sheet will be reviewed during the safety meeting per annual scheduled review. Any identified issues will be reviewed at the monthly QAPI meeting for recommendations.</p>	03/24/2014	

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	<p>03/10/14, battery operated smoke detectors are installed in each of 65 resident sleeping rooms. Manufacturer's specifications affixed to each First Alert Model SA710 smoke detector stated to clean the detector monthly. Based on interview at the time of record review and of the observations, the Maintenance Director stated each battery operated smoke detector is cleaned with compressed air at the time of monthly testing but acknowledged cleaning documentation for the most recent twelve month period was not available for review.</p> <p>3.1-19(a)</p>			