

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E657	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
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NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
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K 0000 Bldg. 01	<p>A Life Safety 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: 10/06/15</p> <p>Facility Number: 000483 Provider Number: 15E657 AIM Number: 100273470</p> <p>At this Life Safety Code survey, Silver Memories Health Care 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 V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detection in all resident sleeping rooms. The facility has a capacity of 29 and had a census of 22 at the time of this visit.</p>	K 0000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective November 5, 2015 to the Life Safety Code Recertification Survey conducted on October 06, 2015.</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 0025 SS=D Bldg. 01	<p>All areas where the residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review completed on 10/09/15 - DA</p> <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 observations and interview, the facility failed to ensure the smoke barriers in 1 of 1 ceiling was constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable 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 affects 4</p>	K 0025	<p>K0025 It is the practice of this facility to assure that smoke barriers are constructed to provide at least one half hour fire resistance rating <i>The correction action taken for those residents found to be affected by the deficient practice include:</i> 4 Residents total found to be affected by this practice, all residing in rooms 10 & 11. #1 Room 10 ceiling had a one inch circular hole in the drywall, this item has been patched and corrected #2 The east hall corridor has ceiling by the exit door had a three inch</p>	11/05/2015

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	<p>residents who reside on the East Hall in resident room 10 and 11.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor during a tour of the facility on 10/06/15 from 9:15 a.m. to 12:50 p.m., the following locations had ceiling drywall missing;</p> <ol style="list-style-type: none"> 1. Resident room 10 ceiling had a one inch circular area of drywall missing near the door. 2. The East Hall corridor ceiling by the exit door had a three inch circular area of drywall missing. 3. The East Hall attic access panel, located at the south end of the East Hall next to the dining room entrance, had a three inch section of drywall missing in the corner of the access panel. Resident room 10 ceiling drywall, the East Hall corridor ceiling drywall and the East Hall attic access panel drywall missing was verified by the maintenance supervisor at the time of observations and by the maintenance supervisor at the exit conference on 10/06/15 at 12:55 p.m. <p>3.1-19(b)</p>		<p>circular gap area with drywall missing, this item has been patched and will be painted.</p> <p>#3 The east hall attic access panel, located at the south end of east hall has a three inch section of the drywall missing, the Maintenance Director will replace the panel with a new piece of drywall Other residents that have the potential to be affected have been identified by: Potentially all residents could be effected. No additional areas were identified per review. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The maintenance department has been in-serviced related to assuring that all fire barriers must remain intact and that when a issue is noticed with fire barriers-it must be addressed/corrected immediately. The corrective action taken to monitor performance to assure compliance through quality assurance is: Assuring that there is adequate fire barriers throughout the facility is a part of the preventive maintenance review and will be included in the facility's quarterly QA meetings. The Administrator, or designee, will be responsible for assuring all areas are built appropriately. Any identified issues will be immediately addressed. The Administrator, or designee, will</p>				

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K 0029 SS=E Bldg. 01	<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 1 sprinklered laundry room was separated from the West Hall by smoke resistant partitions. This deficient practice affects 2 residents who reside in room 9 on the West Hall, which is located next to the laundry room and 6 residents who reside on the Center Hall in room 6, 7, and 8 up to the smoke barrier door.</p> <p>Findings include:</p> <p>Based on observation on 10/06/15 at 10:50 a.m. with the maintenance</p>	K 0029	<p>review the preventive maintenance documentation quarterly for compliance with recommendations as needed. The date the systemic changes will be completed: November 5, 2015</p> <p>K029 It is the practice of this facility to ensure that one hour firerated construction barriers are provided with or an approved automaticfire extinguishing system when the fire system is used, the areas are separatedfrom other spaces by smoke resisting partitions and doors The correction action taken for those residents found to be affected by the deficient practice include: The deficient practice affects 2 residents in room 9 on the west wall, which is located next to the laundry room and also the potential to affect 6 other residents who reside in</p>	11/05/2015	

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	<p>supervisor, the laundry room north wall had two, one foot by one foot square sections of drywall missing with wooden studs exposed behind the wash machine and the dryer. Based on an interview with the maintenance supervisor on 10/06/15 at 10:55 a.m., the drywall was cut out to repair water pipe damage six months ago and has not been repaired. This was verified by the maintenance supervisor at the time of observation and acknowledged by the maintenance supervisor at the exit conference on 10/06/15 at 12:50 p.m.</p> <p>3.1-19(b)</p>		<p>rooms 6, 7 and 8 up to the smoke door The Maintenance Director will patch the two 1 x1 foot holes in the laundry roomwall which adjoin to room 9. Other residents that have the potential to be affected have been identified by: Potentially all residents could be effected. No additional areas were identified in the 2567. The measures or systematic changes that have been put into placeto ensure that the deficient practice does not reoccur include: The maintenance director will review all fire barrier and wall areas monthly on PMs and will immediately address any issues found as needed. The maintenance director will be in-serviced on assuring that fire barriers and walls are reviewed in accordance with the preventive maintenance plan The corrective action taken to assure compliance through quality assurance is: Assuring that there are fire barrier PM checks in the monthly PM log and the results along with any action taken will be reported to QA. The Maintenance Director, or designee, will be responsible for assuring all areas are protected appropriately. Any identified issues will be immediately addressed. The Administrator, or designee, will review the preventive maintenance documentation</p>		

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K 0046 SS=E Bldg. 01	<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 observation and interview, the facility failed to ensure 4 of 20 battery backup lights were maintained to provided at least a 1 1/2 hour duration in accordance with Section 7.9.</p> <p>This deficient practice affects 18 of 22 residents in the facility who reside on the North Hall in resident room 9, and the Center Hall in resident rooms 1, 2, 3, 4, 5, 6, 7, and 8.</p> <p>Findings include:</p> <p>Based on observations on 10/06/15 during a tour of the facility from 9:15 a.m. to 12:45 p.m. with the maintenance supervisor, the North Hall corridor battery backup double light fixture, the North Hall outside battery backup double light fixture, and the Center Hall corridor battery backup double light fixture each failed to light when the test buttons were depressed. Based on an interview with the maintenance supervisor at the time of observations, it was stated the North Hall</p>	K 0046	<p>quarterly for compliance with recommendations as needed.</p> <p>The date the systemic changes will be completed: November 5, 2015</p> <p>K046 It is the practice of this facility to ensure emergency lighting of at least 90 minutes in duration. The correction action taken for those residents found to beaffected by the deficient practice include: The deficient practice affects 18 of 22 residents who reside on the north hall, in resident room 9, and the center hall in resident rooms 1,2, 3, 4, 5, 6, 7, and 8. The Maintenance Director has ordered new emergency lights and replacement batteries to replace and/or repair defective emergency lighting to ensure at least a 1 1/2 hour duration of emergency back up lighting is provided. Other residents that have the potential to be affected have beenidentified by: Potentially all residents could be effected. No additional areas were identified in the 2567. The measures or systematic changes that have been put into placeto ensure that the deficient practice does not reoccur include: The</p>	11/05/2015

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K 0047 SS=E Bldg. 01	<p>corridor, North Hall outside exit and Center Hall corridor battery backup light battery packs were burned out and need replaced. This was verified by the maintenance supervisor at the time of observations and acknowledged by the maintenance supervisor at the exit conference on 10/06/15 at 12:50 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to ensure 3 of 7 exit signs</p>			K 0047	<p>maintenance director will test each emergency light during month PMs and will run an extended test annually on each unit to ensure function. The maintenance director has been in-serviced on assuring that back-up lighting checks are part of the preventive maintenance program The corrective action taken to assure compliance through quality assurance is: Assuring that the emergency lighting PM checks are completed monthly. The PM log and the results along with any action taken will be reported to QA, no less than quarterly. The Administrator or designee, will be responsible for assuring all areas are protected appropriately. Any identified issues will be immediately addressed. The Administrator, or designee, will review the preventive maintenance documentation quarterly for compliance with recommendations as needed. The date the systemic changes will be completed: November 5, 2015</p> <p>K047 It is the practice of this facility to ensure that exit and directional signs are displayed</p>		11/05/2015

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	<p>were continuously illuminated. This deficient practice affects 18 of 22 residents in the facility who reside on the North Hall in resident room 9, and the Center Hall in resident rooms 1, 2, 3, 4, 5, 6, 7, and 8.</p> <p>Findings include:</p> <p>Based on observations on 10/06/15 during a tour of the facility from 9:15 a.m. to 12:45 p.m. with the maintenance supervisor, the dining room exit sign, the North Hall exit sign, and the Center Hall exit sign failed to light when the test button was depressed. Based on an interview with the maintenance supervisor at the time of observations, it was stated the exit signs battery packs are dead and need replaced. This was verified by the maintenance supervisor at the time of observations and acknowledged by the maintenance supervisor at the exit conference on 10/06/15 at 12:50 p.m.</p> <p>3.1-19(b)</p>		<p>with continuous illumination also served by the emergency lighting system. The correction action taken for those residents found to beaffected by the deficient practice include: This deficient practice affects 18 of 22 residents in the facility who reside on the north hall in resident room 9, and the center hall in resident rooms 1, 2, 3, 4, 5, 6, 7 and 8. The Maintenance Director has ordered 3 new exit lights and they will installed Other residents that have the potential to be affected have beenidentified by: Potentially all residents could be effected. No additional areas were identified in the 2567. The measures or systematic changes that have been put into place to ensure that the deficient practice does not reoccur include: The maintenance director will ensure, monthly during PMs, that all exit lights are fully functional and will documenton PMs. The maintenance director will be in-serviced related to checking to assure that the exit signs are continuously illuminated as part of preventive maintenance The corrective action taken to assure compliance through qualityassurance is: Assuring that the exit lights PM checks are completed monthly. The PM log and the results along with any action taken will be reported to QA, no less than quarterly The</p>				

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K 0048 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide 1 of 1 written emergency fire safety plan that incorporated all items listed in NFPA 101, Section 19.7.2.2.</p> <ol style="list-style-type: none"> 1. Use of alarms. 2. Transmission of alarms to 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 affects all residents, staff and visitors in the event of an emergency.</p>	K 0048	<p>Administrator or designee, will be responsible for assuring all exit signs are illuminated appropriately. Any identified issues will be immediately addressed. The Administrator, or designee, will review the preventive maintenance documentation quarterly for compliance with recommendations as needed. The date the systemic changes will be completed: November 5, 2015</p> <p>K048 It is the practice of this facility to ensure that there is a written plan for protection of all patients and for their evacuation in the event of an emergency. The correction action taken for those residents found to be affected by the deficient practice include: This deficient practice has the potential to affect all residents, staff and visitors to the facility. No specific residents were identified in the 2567 Other residents that have the potential to be affected have been identified by: Potentially all residents could be effected. No additional areas were identified in the 2567. The measures or systematic changes that have been put into placeto ensure</p>	11/05/2015	

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K 0050 SS=F Bldg. 01	<p>Findings include:</p> <p>Based on record review on 10/06/15 at 9:10 a.m. with the maintenance supervisor, the facility's fire safety plan labeled Resident Care Policy Fire Prevention did not address the transmission of the fire alarm to the fire department and lacked information addressing resident room battery operated smoke detectors. This was verified by the maintenance supervisor at the time of record review and acknowledged by the maintenance supervisor at the exit conference on 10/06/15 at 12:50 p.m.</p> <p>3.1-19(b)</p> <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</p>		<p>that the deficient practice does not reoccur include: The written disaster policy has been updated to include the necessary information. The policy includes information related to the transmission of the fire alarm to the fire department. It has also been updated to include information on addressing resident room battery operated smoke detectors The maintenance director has been in-serviced related to the updates on the policy The corrective action taken to assure compliance through quality assurance is: The administrator is responsible for assuring that the fire protection policy is up to date with mandatory information per the regulation. The Administrator, or designee, will review the fire protection plan annually as part of the Quality Assurance process. Any issue identified will be immediately corrected The date the systemic changes will occur: November 5, 2015</p>				

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	<p>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 on all shifts for 1 of 4 quarters over the past year. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Log Sheets with the maintenance supervisor on 10/06/15 at 9:00 a.m., there was no fire drill documentation for the first shift, third quarter of the year 2015. Additionally, based on interview with the maintenance supervisor during the review of the Fire Drill Log Sheets, there was no other documentation available for review to verify this drill was conducted. This was verified by the maintenance supervisor at the time of record review and acknowledged by the maintenance supervisor at the exit conference on 10/06/15 at 12:50 p.m.</p> <p>3.1-19(b)</p>	K 0050	<p>K050 It is the practice of this facility to ensure that 3 fire drills are held in varying conditions and times, at least quarterly on each shift (totaling 3 per qtr) The corrective action taken for those residents found to beaffected by the deficient practice include: This deficient practice has the potential to affect all residents, staff and visitors to the facility. Other residents that have the potential to be affected have beenidentified by: Potentially all residents could be effected. The measures or systematic changes that have been put into placeto ensure that the deficient practice does not reoccur include: The Maintenance Director was in-serviced on K50 and the importance of holdingall scheduled fire drills on all shifts at varying times quarterly to ensure the safety of all residents, staff andvisitors. The corrective action taken to assure compliance through qualityassurance is: The maintenance director will ensure that each month one fire drill is held for one of the three shifts-making sure to varying times and complete one drill per quarter, per shift. The Administrator or designee, will be responsible for assuring monthly drills occur and are documented appropriately-per facility</p>	11/05/2015			

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K 0052 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure 14 of 14 smoke detectors were tested for sensitivity every two years in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where</p>	K 0052	<p>policy. Any identified issues will be immediately addressed. The Administrator, or designee, will review the fire drill documentation quarterly for compliance with recommendations as needed.</p> <p>The date the systemic changes will be completed: November 5, 2015</p> <p>K052 It is the practice of this facility to ensure that a fire alarm system for life safety is fully functional and tested at the appropriate times by an outside contracted vendor to ensure functionality. The correction action taken for those residents found to be affected by the deficient practice include: This deficient practice has the potential to affect all residents, staff and visitors to the facility. Other residents that have the potential to be affected have been identified by: Potentially all residents could be effected. The measures or systematic changes that have been put into placeto ensure that the deficient practice does not reoccur include: The Maintenance Director was</p>	11/05/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E657	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/06/2015
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042		
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	<p>nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires inspection, testing and maintenance reports be provided for the owner or a designated representative. It shall be the responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having</p>		<p>in-serviced on the importance of a clean and orderly life safety manual. The Maintenance Director was able to produce the documentation related to smoke detector sensitivity testing that was missing during the survey and show that the facility was indeed not out of compliance for the 2 year window for smoke detector sensitivity tests. Provision of services for the sensitivity testing is the preventive maintenance schedule for every 2 years The corrective action taken to assure compliance through quality assurance is: The maintenance director will ensure that the life safety book is kept clean and orderly and that the facility will have an outside contracted vendor to complete the smoke detector sensitivity test in accordance with the regulation The Administrator or designee, will be responsible for assuring bi-annual smoke detector sensitivity tests are completed-according to NFPA 72 guidelines. Any identified issues will be immediately addressed. The Administrator, or designee, will review the preventive maintenance documentation annually for compliance with recommendations as needed. The date the systemic changes will be completed: November 5, 2015</p>		

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K 0061 SS=F Bldg. 01	<p>jurisdiction. This deficient practice affects all residents, staff and all visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review on 10/06/15 at 9:00 a.m. with the maintenance supervisor, there was no smoke detector sensitivity test report available for review for fourteen smoke detectors located throughout the facility. The only records provided for review was an annual functional test of fire alarm system devices from Koorsen Fire and Security dated 04/29/15. This was verified by the maintenance supervisor at the time of record review and acknowledged at the exit conference on 10/06/15 at 12:50 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 Based on record review and interview, the facility failed to ensure 1 of 1 Post Indicator Valve (PIV) was provided with an electrical alarm which alarmed when the valve was closed. LSC Section 9.7.2.1 requires supervisory attachments</p>	K 0061	K061 It is the practice of this facility to ensure that this facility has a automatic sprinkler system that has valves with supervisory attachments so that at least one local alarm will sound when the valves are closed.	11/05/2015			

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	<p>to be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. This deficient practice affects all residents in the facility if the water to the sprinkler system was shut off and not detected due to lack of supervision.</p> <p>Findings include:</p> <p>Based on record review on 10/06/15 at 9:00 a.m. with the maintenance supervisor, the annual fire alarm system inspection record from Koorsen Fire and Security dated 04/29/15 indicated "the Post Indicator Valve failed to alarm to the fire alarm panel." Based on an interview with the maintenance supervisor on 10/06/15 at the time of record review, there was no documentation available for review to indicate the post indicator valve was repaired or replaced after the Koorsen Fire and Security annual fire alarm system inspection conducted on 04/29/15. The lack of the post indicator valve alarming at the fire alarm panel was verified by the maintenance supervisor at the time of record review and acknowledged by the maintenance supervisor at the exit conference on</p>		<p>The correction action taken for those residents found to beaffected by the deficient practice include: This deficient practice has the potential to affect all residents, staff and visitors to the facility. Maintenance Director is getting a quote from outside contracted vendor to have the PIV repaired to provided alarm notification if closed. Other residents that have the potential to be affected have beenidentified by: Potentially all residents could be affected.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not reoccur include: The Maintenance Director was in-serviced on importance that valve sounds into the fire panel when closed. This item will be replaced asap by facility vendor-SafeCare. The corrective action taken to assure compliance through qualityassurance is: The Maintenance Director will add this item to the monthly PMs schedule and report results to QA. The Administrator or designee, will be responsible for ensuring that the PIV value is checked monthly on the PM and identified issues will be immediately addressed. The Administrator, or designee, will review the preventive maintenance documentation quarterly for compliance with recommendations as needed.</p>	

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	10/06/15 at 12:50 p.m. 3.1-19(b)		<i>The date the systemic changes will be completed: November 5, 2015</i>		