STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	155736		03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL POND HEALTH CAMPUS	1014 MILL POND LN GREENCASTLE, IN 46135

(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
K 0000 Bldg. 01	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). Survey Date: 03/24/16 Facility Number: 004550 Provider Number: 155736 AIM Number: 200526450 At this Life Safety Code survey, Mill Pond Health Campus 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. This facility, located on the south and east end of a one story building, 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 areas open to the corridors. The facility has smoke detectors hard wired to the fire alarm system installed in 36 of 36	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey in conjunction with Life Safety Code Recertification Survey on March 24th, 2016. Please accept this plan of correction as the provider's credible allegation of compliance.The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	resident sleeping rooms. The facility has a capacity of 68 and had a census of 55 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review on 03/30/16 - DA			
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one 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 in approved frames. 8.3, 18.3.7.3, 18.3.7.5 Based on observation and interview, the facility failed to ensure openings in 2 of 11 smoke barriers were protected to maintain at least a one hour fire resistance rating for the smoke barrier. This deficient practice could affect 25 residents, staff or visitors. Findings include: Based on observation with the Director of Plant Operations during a tour of the facility from 11:30 a.m. to 2:15 p.m. on 03/24/16, the attic smoke barrier wall above the ceiling at the corridor door set	K 0025	The two inch diameter hole for the passage of five cables and the one inch in diameter open ended conduit which penetrated the attic smoke barrier wall above the ceiling at the corridor door set by the Living Room was caulked with fire rated caulking 4/4/16. The Director of Plant Operations will examine the attic area for any additional penetrations in attic smoke barrier walls, document his	04/23/2016

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	by the Living Room had a two inch in diameter hole for the passage of five cables and a one inch in diameter open ended conduit which penetrated the wall and were not firestopped. In addition, each of two 2-inch in diameter open ended conduits which penetrated the attic smoke barrier wall above the ceiling at the corridor door set by Room 104 were also not firestopped. Based on interview at the time of the observations, the Director of Plant Operations acknowledged the aforementioned attic smoke barrier openings were not firestopped to maintain at least a one hour fire resistance rating for each smoke barrier. 3.1-19(b)		findings and will report to the Executive Director by 4/11/16 any penetrations. Any newly discovered penetrations will be caulked with fire rated caulking within 48 hours of their discovery. Date of compliance: 4/23/16 The Director of Plant Operations will examine the attic smoke barrier walls for any new penetrations once a month for three month and once a quarter for three quarters. The Director of Plant Operations will report to the Executive Director his findings. Any newly discovered penetrations will be caulked with fire rated caulking within 48 hours of their discovery.	
K 0029 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1.			

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	1. Based on record review, observation and interview; the facility failed to ensure 11 of 21 hazardous areas such as fuel fired heater locations were enclosed with one hour separation. Doors to hazardous areas are self-closing or close automatically upon activation of the fire alarm system. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of facility blueprint documentation with the Director of Plant Operations during record review from 9:40 a.m. to 11:30 a.m. on 03/24/16, the facility has 11 attic mounted natural gas fired furnaces above each smoke compartment in the facility. Based on observations with the Director of Plant Operations during a tour of the facility from 11:30 a.m. to 2:15 p.m. on 03/24/16, a natural gas fired furnace was noted in the attic above the smoke barrier door set by the south entrance to the Main Dining Room, in the attic above the smoke barrier door set by the Living Room and in the attic above the 300 Hall. Each of the three observed attic mounted natural gas fired furnaces were not enclosed in one hour fire rated construction. Based on interview at the time of record review and of the	K 0029	1. We respectfully request a Life Safety Code Waiver. We have applied for a Waiver Request. Please see attached. Date of completion: 8/11/16 2. The door on the Storage Room by the nurse's station by Harvest Hall was replaced with a door that has a ¾-hour fire protection rating on 4/6/16. The Director of Plant Operations will audit the enterior doors of the facility to identify any additional doors that should have a 3/4–hour fire potection rating and report his finding to the Executive Director by 4/16/16. Any additional identified doors will be replaced. Date of compliance: 4/23/16	04/23/2016

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	observations, the Director of Plant Operations acknowledged each of 11 attic mounted natural gas fired furnace locations were not enclosed in one hour fire rated construction. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 10 corridor doors serving hazardous areas such as storage rooms larger than 100 square feet storing combustible material have a 3/4-hour fire protection rating. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Storage Room by the nurse's station by Harvest Hall. Findings include: Based on observation with the Director of Plant Operations during a tour of the facility from 11:30 a.m. to 2:15 p.m. on 03/24/16, the Storage Room by the nurse's station by Harvest Hall which measured 144 square feet in size had no fire resistance rating label affixed to the corridor door. The Storage Room contained combustible nursing supplies on storage shelves in the room. Based on interview at the time of observation, the Director of Plant Operations stated he was unaware of the fire resistance rating			

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	of the corridor door and acknowledged the aforementioned hazardous area corridor door had no fire resistance rating label affixed to the door. 3.1-19(b)			
K 0038 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1 1. Based on observation and interview, the facility failed to ensure the means of egress through 2 of 10 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. 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 20 residents, staff and visitors if needing to exit the facility from the courtyard.	K 0038	**1.** The exit sign identifying the west door across from the Therapy Room has been removed. This is no longer an emergency exit. Signage stating "This is not a Fire Exit" will be installed at the west door across from Therapy. Evacuation Route information posted throughout the campus will be updated. **2.** A Contractor Proposal was obtained 4/8/16 to remove and replace the sidewalk outside the 200 hall corridor to meet the required grade and to install a handrail on both sides of the sidewalk. Date of compliance: 4/23/16	04/23/2016

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	Findings include: Based on observations with the Director of Plant Operations during a tour of the facility from 11:30 a.m. to 2:15 p.m. on 03/24/16, the west exit door from the facility across from the Therapy Room was marked as a facility exit and led to an outside courtyard which had two exit doors leading to the public way which were each magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of the observations, the Director of Plant Operations acknowledged the four digit code was not posted at each of two courtyard exit doors leading to the public way. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 10 exit accesses was provided with handrails. LSC 7.2.2.4.2 requires stairs and ramps shall have handrails on both sides. In addition, handrails shall be provided within 30 inches of all portions of the required egress width of stairs. The required egress width shall be provided			

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	along the natural path of travel. This deficient practice could affect 10 residents, staff and visitors if needing to exit the facility from the 300 Hall. Findings include: Based on observation with the Director of Plant Operations during a tour of the facility from 11:30 a.m. to 2:15 p.m. on 03/24/16, the 300 Hall exit discharge to the public way had a nineteen and one half foot sloping sidewalk ramp with a twelve inch rise over the length of the ramp which was not provided with handrails. Based on interview at the time of observation, the Director of Plant Operations acknowledged the 300 Hall exit discharge to the public way was not provided with handrails. 3.1-19(b)			
K 0046 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. Based on record review, observation, and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 2 of 2 battery operated emergency lights. LSC 7.9.3 Periodic Testing of Emergency	K 0046	The Director of Plant Operations will conduct a 30 second functional test on battery operated emergency lighting equipment monthly for twelve months and	04/23/2016

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	Lighting Equipment requires a 30 second 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. Findings include: Based on review of Vanguard Alarm Services "Inspection and Testing Certificate" documentation dated 08/26/15 with the Director of Plant Operations during record review from 9:40 a.m. to 11:30 a.m. on 03/24/16, documentation of monthly functional testing for each of two battery powered emergency lighting systems in the facility was not available for review. The 08/26/15 documentation only contained annual testing documentation for each of two battery powered emergency lighting systems for not less than 1 ½ -hr. duration. Based on observations with the Director of Plant Operations during a tour of the facility from 11:30 a.m. to 2:15 p.m. on 03/24/16, two battery powered		conduct an 1 ½-hr. long test annually. The Executive Director will review documentation with the Director of Plant Operations to verify the test has been completed and documented appropriately monthly for twelve months.	

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	emergency lighting systems were located in the facility including the transfer switch location and each light functioned when its respective test button was pushed. Based on interview at the time of record review and of the observations, the Director of Plant Operations acknowledged monthly functional testing documentation for the aforementioned two battery operated emergency lights for the most recent twelve month period was not available for review. 3.1-19(b)			
K 0050 SS=F Bldg. 01	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. 18.7.1.2, 19.7.1.2 1. Based on record review and interview, the facility failed to document fire drills conducted on the second shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors.	K 0050	The Director of Plant Operations will conduct a fire drill on every shift once a quarter at varying times during various conditions (for a total of 3 fire drills, one per	04/23/2016

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	Findings include: Based on review of "Record of Drills" documentation with the Director of Plant Operations during record review from 9:40 a.m. to 11:30 a.m. on 03/24/16, documentation of a fire drill conducted on the second shift (2:00 p.m. to 10:00 p.m.) in the third quarter (July, August, September) of 2015 was not available for review. Based on interview at the time of record review, the Director of Plant Operations acknowledged documentation of a fire drill conducted on the second shift in the third quarter of 2015 was not available for review. 3.1-19(b) 2. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Record of Drills" documentation with the Director of Plant Operations during record review from 9:40 a.m. to 11:30 a.m. on 03/24/16, third shift (10:00 p.m. to 6:00 a.m.) fire drills		month on different shifts, per quarter). The Executive Director wil review documentation with the Director of Plant Operations to verify the test has been completed and documented appropriately monthly for twelve months.	

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	conducted on 05/13/15, 08/03/15 and 11/18/15 were conducted at, respectively, 6:15 a.m., 6:00 a.m. and 5:40 a.m. Based on interview at the time of record review, the Director of Plant Operations acknowledged the aforementioned third shift fire drills were not conducted at unexpected times under varying conditions. 3.1-19(b)			
K 0052 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, Based on observation and interview, the facility failed to maintain 4 of 159 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect ten residents, staff or visitors in the	K 0052	All four smoke detectors, identified during the survey, were relocated at least 3 feet from an air supply diffuser or return air opening by Vanguard 4/7/16. The four identified smoke detectors were located: 1. In the main lobby corridor 2. In the staff breakroom 3. In the Medical Records	04/23/2016

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	vicinity of the main lobby. Findings include: Based on observations with the Director of Plant Operations during a tour of the facility from 11:30 a.m. to 2:15 p.m. on 03/24/16, the smoke detector in the corridor in the main lobby was located on the ceiling within two feet of an air supply vent and the smoke detector in the Staff Breakroom was located on the ceiling 18 inches from an air supply vent. In addition, the smoke detector installed in Medical Records and in the kitchen by the sink by the cutting board were each located on the ceiling one foot from an air supply vent. Based on interview at the time of the observations, the Director of Plant Operations acknowledged the aforementioned four smoke detectors were each located on the ceiling within three feet of an air supply vent. 3.1-19(b)		office 4. In the kitchen in the sink area next to the cutting board The Director of Plant Operations will examine smoke detectors throughout the facility to identify any additional smoke detectors that are located within 3 feet of an air supply difuser. The Director of Plant Operations is to report his findings to the Executive Director. Any identified smoke detectors will be relocated. Date of compliance: 4/23/16	
K 0062 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the	K 0062	The one half inch flexible	04/23/2016

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	facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. LSC 9.7.1 states all automatic sprinkler systems shall be maintained in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 states sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect ten residents, staff and visitors in the vicinity of the Main Dining Room. Findings include: Based on observation with the Director of Plant Operations during a tour of the facility from 11:30 a.m. to 2:15 p.m. on 03/24/16, a one half inch flexible electrical conduit was run through one sprinkler pipe hanger near the attic smoke barrier wall above the corridor outside the south entrance to the Main Dining Room. Based on interview at the time of observation, the Director of Plant Operations acknowledged the aforementioned sprinkler pipe location was being used to support nonsystem components. 3.1-19(b)		electrical conduit was removed from the sprinkler pipe hanger near the attic smoke barrier wall above the corridor outside the south entrance to the Main Dining Room and attached to the supporting 2x6s 4/6/16. The Director of Plant Operations will examine all sprinkler pipe hangers in the attic to determine if the sprinkler pipe hangers are being used inappropriately. The Director of Plant Operations will document his findings and report his findings to the Executive Director by 4/11/16. Any inappropriate findings will be corrected. Date of compliane: 4/23/16 The Director of Plant Operations will examine the sprinkler pipe hangers in the attic once a quarter for four quarters, document and report his findings to the Executive Director. All needed corrections will be completed within 48 hours	

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	155736		03/24/2016

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			of their discovery.	
K 0067 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2 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 heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation 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 could affect all residents, staff and visitors.	K 0067	Vanguard inspected the dampers in the HVAC air supply ductwork throughout the facility and provided necessary maintence 3/29/16. Documentation is available for review.	04/23/2016

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	Findings include: Based on record review with the Director of Plant Operations from 9:40 a.m. to 11:30 a.m. on 03/24/16, documentation of fire damper inspection and maintenance within the most recent four year period was not available for review. Based on observations with the Director of Plant Operations during a tour of the facility from 11:30 a.m. to 2:15 p.m. on 03/24/16, fire dampers were noted in HVAC air supply ductwork throughout the facility. The fire damper in HVAC air supply ductwork in the Breakroom and in the Living Room each had a manufacture date of August 2004 listed on the fire damper. Based on interview at the time of record review and of the observations, the Director of Plant Operations acknowledged fire damper inspection and maintenance documentation within the most recent four year period for all facility fire dampers was not available for review. 3.1-19(b)			
K 0074 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics			

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	and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 o Newly introduced upholstered furniture and mattresses means purchased since March, 2003.			
	Based on record review, observation and interview; the facility failed to ensure window curtains and valences in all smoke compartments with resident access were flame resistant. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Director of Plant Operations from 9:40 a.m. to 11:30 a.m. on 03/24/16, window curtain	K 0074	A Flame Spread Manual for the facility was obtained from the home office 3/25/16 and is available for review	04/23/2016

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	and valence flame resistance documentation was not available for review. Based on observations with the Director of Plant Operations during a tour of the facility from 11:30 a.m. to 2:15 p.m. on 03/24/16, window curtains in the Executive Director's Office, Therapy, Living Room, Private Dining Room and 400 Hall Lounge had no affixed documentation stating each curtain was inherently flame retardant. In addition, window valences in each resident sleeping room throughout the facility had no affixed documentation stating each window valence was inherently flame retardant. Based on interview at the time of record review and of the observations, the Director of Plant Operations stated window curtains and resident room window valences are not treated with a flame retardant material and acknowledged window curtain and window valence flame resistant documentation was not available for review. 3.1-19(b)			

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K 0154 SS=C Bldg. 01	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 shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1. 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 55 of 55 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. Findings include: Based on review of "Emergency Disaster Preparedness Manual: Emergency Fire Watch" documentation with the Director of Plant Operations during record review	K 0154	The written fire watch policy for the facility will be updated with the name of the current fire alarm system monitoring company. In addition, the policy will be updated to include notification of the insurance carrier, along with the current insurance carrier's name and contact information.	04/23/2016

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	from 9:40 a.m. to 11:30 a.m. on 03/24/16, 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 current fire alarm system monitoring company. In addition, the written fire watch policy did not include notification of the insurance carrier. The aforementioned fire watch policy stated to contact "Dictograph Security Systems" should the automatic sprinkler system be impaired for four hours or more in a 24 hour period. Based on interview at the time of record review, the Director of Plant Operations stated Vanguard Alarm Services is the current fire alarm system monitoring company not Dictograph Security Systems and 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 the current fire alarm system monitoring company and insurance carrier. 3.1-19(b)			