STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY	1380 E COUNTY LINE RD S INDIANAPOLIS, IN 46227

(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
K010000	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: 04/22/13 Facility Number: 000220 Provider Number: 155327 AIM Number: 100267650 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, University Heights Health and Living Community 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), and 410 IAC 16.2. Building 0102 was surveyed using Chapter 19, Existing Health Care Occupancies. This one story facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building 0102 constructed prior to 2003 was determined to be of Type III	K010000	This plan of correction is to serve as University Heights Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by University Heights Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	

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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	(200) 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 battery operated smoke detectors in all resident sleeping rooms in the 100, 200, 300, 400, 500, 600 and 700 Hall. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms in the 900 Hall. The facility has a capacity of 176 and had a census of 148 at the time of this visit. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached garage providing facility storage services. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/24/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010029 SS=E	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 facility failed to ensure 1 of 12 doors serving hazardous areas such as the kitchen automatically close and latch into the door frame. This deficient practice could affect 30 residents, staff and visitors in the vicinity of the kitchen. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 10:45 a.m. to 12:30 p.m. on 04/22/13, the service corridor west entry door to the kitchen is equipped with a self closing device but the closing device did not fully swing the door to self close and automatically latch into the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the service corridor west entry door to the kitchen does not	K010029	**K029 NFPA 101 Life Safety Code standard** I. Kitchen door was adjusted 04.22.2013 to close and latch in the door frame. II. An audit was completed of the entire facility to ensure that all doors serving hazardous areas closed and latched properly. Adjustments were made as needed. III. The Maintenance Director will report results of the audit to the Administrator or designee. All doors serving hazardous areas will be adjusted so they close and latch. Results of the audit will be reported in the monthly Continuously Quality Review Committee for further intervention and follow up. Monthly audits will be completed until there is 100 % compliance then annually thereafter. Education was provided to the Maintenance Director and	05/22/2013

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	automatically close and latch into the door frame. 3.1-19(b)		support staff regarding auditing doors that serve hazardous areas for closing and latching properly. IV. The Continuously Quality Review Committee will monitor the audits to ensure that all doors serving hazardous areas close and latch. V. Completion Date May 22, 2013	

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K010038 SS=E	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. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 10 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 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 30 residents, staff and visitors if needing to exit the facility through the service corridor by the Main Dining Room. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 10:45 a.m. to 12:30 p.m. on 04/22/13, the service corridor exit by the Main Dining Room was marked as a facility exit, the exit door was	K010038	**K038 NFPA 101 Life Safety Code standard** I. Egress Magnetic lock installed 05 07.2013 to service hall door. Device will release Magnetic lock after 15 seconds of pressure. New sign installed posted as egress door II. Director of Maintenance conducted an audit of all egress doors to ensure all were equipped with a Magnetic Locking device that would release every time there is 15 seconds of pressure. III. The Maintenance Director will report results of the audit to the Administrator or designee. Release devices will be installed on any egress door. Results of the audit will be reported in the monthly Continuously Quality Review Committee for further intervention and follow up. Monthly audits will be completed until there is 100 % compliance then annually thereafter. The Maintenance Director and support staff was offered education regarding the systemic change and auditing process. IV. The Continuously Quality Review Committee will monitor the audits to ensure that any egress door has the proper releasing device.	05/22/2013

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	magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview with the Maintenance Director at the time of observation and with the Administrator during the exit conference at 4:15 p.m. on 04/22/13, residents who have a clinical diagnosis to be in a secure building are housed only in a portion of the building in the 300 Hall and acknowledged the exit code was not posted at the service corridor exit by the Main Dining Room for use by residents without the clinical diagnosis requiring specialized security measures. 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)		V. Completion date May 22, 2013	

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K010046 SS=C	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. Based on record review, observation and interview; the facility failed to document annual testing of emergency lighting in accordance with LSC 7.9 for 1 of 1 battery powered lights. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual functional test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour 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 "Direct Supply-TELS Logbook Documentation" with the Maintenance Director during record review from 9:10 a.m. to 10:45 a.m. on 04/22/13, documentation of an annual ninety minute test for the battery powered emergency lights in the facility within the most recent twelve month period was not available for review. Based on observation with the Maintenance	K010046	**K046 NFPA 101 Life Safety Code standard** I. Annual 90 minute test for battery powered emergency lights in the facility was conducted on January 31, 2013, see attached. II. Director of Maintenance will complete a 90 minute test for battery powered emergency lights in the facility annually. Hard copy documentation will be kept in the Life Safety binder kept in the Maintenance Office for review by ISDH Surveyors and Life Safety Inspectors. III. Director of Maintenance will complete a 90 minute test for battery powered emergency lights in the facility annually. Hard copy documentation will be kept in the Life Safety binder kept in the Maintenance Office for review by ISDH Surveyors and Life Safety Inspectors.Education was provided to the Director of Maintenance and support staff regarding the 90 minute test for battery powered emergency lights in the facility. IV. The Continuously Quality Review Committee will monitor the audits to ensure that 90 minute test documentation has a hard copy	05/22/2013

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	Director during a tour of the facility from 1:15 p.m. to 4:15 p.m. on 04/22/13, one battery powered emergency light was observed installed outside the building at the emergency generator location. Based on interview at the time of record review and of the observation, the Maintenance Director stated the facility does not perform annual ninety minute testing on battery powered emergency lighting systems and acknowledged documentation of an annual ninety minute test within the most recent twelve month period for the battery powered emergency light located outside the building at the emergency generator was not available for review. 3.1-19(b)		placed in Life Safety Binder located in the Maintenance Director's Office. V. Completion Date May 22,2013	

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K010050 SS=F	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 announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to document fire drills conducted on third shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Direct Supply-TELS Logbook Documentation: Fire Drills" with the Maintenance Director during record review from 9:10 a.m. to 10:45 a.m. on 04/22/13, documentation of a fire drill conducted on the third shift for the second quarter of 2012 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of a fire drill conducted on the third shift for the second quarter of 2012 was not available for review. 3.1-19(b)	K010050	**K050 NFPA 101 Life Safety Code standard** I. A third shift fire drill will be conducted by 05.20.2012 including the transmission of the fire alarm signal. II. An audit was completed on all fire drills for last 12 months to ensure that they included the transmission of the fire alarm signal to the fire alarm signal company. III. The Maintenance Director will complete a monthly audit of fire drills to ensure they are conducted quarterly on each shift and include the transmission of the fire signal. Results of the audit will be forwarded monthly to the Continuous Quality Improvement Committee for follow up and intervention. Monthly audits will be completed until there is 100 % compliance then annually thereafter. Education was provided to the Maintenance Director and support staff regarding fire drills to be conducted quarterly on each shift and to include transmission of the	05/22/2013

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			signal to the fire alarm signal company. IV. The Continuously Quality Review Committee will monitor the audits to ensure that all fire drills are conducted quarterly on each shift and to include transmission of the signal to fire alarm signal company. Audits will be complete until there is 100 % compliance, then quarterly thereafter. V. Completion date: May 22, 2013	

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K010144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 40 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply-TELS	K010144	**K 144 NFPA 101 Life Safety Code standard** I. A Generator test was conducted on 05.11.2013 which inspected for battery, electrolyte and oil levels and a complete written record is maintained with the generator log. II. The Director of Maintenance updated the test procedure to include battery, electrolyte and oil levels at intervals of not more than 7 days and shall be maintained in full compliance with the manufacturer's specifications and a complete written record is maintained with the generator log. III. The Director of Maintenance will submit Inspection records to the Continuous Quality Review Committee for batteries are used in connection with essential electrical systems will be inspected at intervals of not more than 7 days and a complete written record is maintained with the generator log. The Maintenance Director will report results of the audit to the Administrator or designee. Results of the audit will be reported in the monthly Continuously Quality Review Committee for further intervention and follow up. Monthly audits will be completed until there	05/22/2013

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	Logbook Documentation "Exercise Generator (with no load)" and "Test Generator Under Load" documentation with the Maintenance Director during record review from 9:10 a.m. to 10:45 a.m. on 04/22/13, weekly emergency generator starting battery inspection records for the forty week period of 07/20/12 through 04/19/13 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of weekly battery inspections after 07/13/12 was not available for review. 3.1-19(b)		is 100 % compliance then annually thereafter. Education was provided to the Maintenance Director and support staff regarding the test procedure and inspection of the generator as well as the logging of the battery, electrolyte and oil levels in the written record at intervals of not more than 7 days that are used in connections essential electrical systems. IV. The Continuously Quality Review Committee will monitor the audits to ensure that a complete written record of the inspections of batteries at intervals of not more than 7 days that are used in connections essential electrical systems. Completion date May 22, 2013	

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K010211 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623			
	Based on observation and interview, the facility failed to ensure 4 of 124 alcohol based hand sanitizers in resident sleeping rooms were not installed over an ignition source. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 8 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:45 a.m. to 12:30 p.m. and from 1:15 p.m. to 4:15 p.m. on 04/22/13, an alcohol based hand sanitizer was located approximately four inches above	K010211	**K 211 NFPA 101 Life Safety Code standard** I. Alcohol based hand sanitizer brackets were re- located away from ignition source for rooms 203, 205, 405, and 715 on May 6, 2013 II. Director of Maintenance completed an audit of the entire facility including each resident bathroom for other locations of Alcohol based hand sanitizer above or adjacent to an ignition source. All brackets located above an ignition source were re-located away from any ignition source III. The Maintenance Director will report results of the audit for brackets located above and adjacent to an ignition source to the Administrator or designee. All	05/22/2013

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	an electrical outlet in the bathroom for resident sleeping Rooms 203, 205, 405 and 715. Each of the aforementioned alcohol based hand sanitizers locations had propylene glycol listed as an ingredient on the packaging of the sanitizer. Based on interview at the time of the observations, the Maintenance Director acknowledged each of the aforementioned hand sanitizer locations was alcohol based and was installed over an ignition source. 3.1-19(b)		brackets located above or adjacent to an ignition source will be re-located away from any ignition source. Results of the audit will be reported in the monthly Continuously Quality Review Committee for further intervention and follow up. Monthly audits will be completed until there is 100 % compliance then annually thereafter. Educations was offered to the Maintenance Director regarding locating alcohol based hand sanitizer brackets away from ignition sources. IV. The Continuously Quality Review Committee will monitor the audits to ensure that each resident bathroom does not have Alcohol based hand sanitizer above or adjacent to an ignition source. Completion date May 22	

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K020000	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: 04/22/13 Facility Number: 000220 Provider Number: 155327 AIM Number: 100267650 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, University Heights Health and Living Community 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), and 410 IAC 16.2. Building 0202 was surveyed using Chapter 18, New Health Care Occupancies. This one story facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building 0202 constructed in 2012 was determined to be of Type V	K020000	This plan of correction is to serve as University Heights Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by University Heights Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED 04/22/2013

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	(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 battery operated smoke detectors in all resident sleeping rooms in the 100, 200, 300, 400, 500, 600 and 700 Hall. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms in the 900 Hall. The facility has a capacity of 176 and had a census of 148 at the time of this visit. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached garage providing facility storage services. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K020046 SS=C	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 Based on record review, observation and interview; the facility failed to document annual testing of emergency lighting in accordance with LSC 7.9 for 1 of 1 battery powered lights. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual functional test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour 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 "Direct Supply-TELS Logbook Documentation" with the Maintenance Director during record review from 9:10 a.m. to 10:45 a.m. on 04/22/13, documentation of an annual ninety minute test for the battery powered emergency lights in the facility within the most recent twelve month period was not available for review. Based on observation with the Maintenance	K020046	**K046 NFPA 101 Life Safety Code standard** I. Annual 90 minute test for battery powered emergency lights in the facility was conducted on January 31, 2013, see attached. II. Director of Maintenance will complete a 90 minute test for battery powered emergency lights in the facility annually. Hard copy documentation will be kept in the Life Safety binder kept in the Maintenance Office for review by ISDH Surveyors and Life Safety Inspectors. III. Director of Maintenance will complete a 90 minute test for battery powered emergency lights in the facility annually. Hard copy documentation will be kept in the Life Safety binder kept in the Maintenance Office for review by ISDH Surveyors and Life Safety Inspectors.Education was provided to the Director of Maintenance and support staff regarding the 90 minute test for battery powered emergency lights in the facility. IV. The Continuously Quality Review Committee will monitor the audits to ensure that 90 minute test documentation has a hard copy	05/22/2013

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	Director during a tour of the facility from 1:15 p.m. to 4:15 p.m. on 04/22/13, one battery powered emergency light was observed installed outside the building at the emergency generator location. Based on interview at the time of record review and of the observation, the Maintenance Director stated the facility does not perform annual ninety minute testing on battery powered emergency lighting systems and acknowledged documentation of an annual ninety minute test within the most recent twelve month period for the battery powered emergency light located outside the building at the emergency generator was not available for review. 3.1-19(b)		placed in Life Safety Binder located in the Maintenance Director's Office. V. Completion Date May 22,2013	

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K020050 SS=F	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 announcement may be used instead of audible alarms. 18.7.1.2 Based on record review and interview, the facility failed to document fire drills conducted on third shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Direct Supply-TELS Logbook Documentation: Fire Drills" with the Maintenance Director during record review from 9:10 a.m. to 10:45 a.m. on 04/22/13, documentation of a fire drill conducted on the third shift for the second quarter of 2012 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of a fire drill conducted on the third shift for the second quarter of 2012 was not available for review. 3.1-19(b)	K020050	**K050 NFPA 101 Life Safety Code standard** I. A third shift fire drill will be conducted by 05.20.2012 including the transmission of the fire alarm signal. II. An audit was completed on all fire drills for last 12 months to ensure that they included the transmission of the fire alarm signal to the fire alarm signal company. III. The Maintenance Director will complete a monthly audit of fire drills to ensure they are conducted quarterly on each shift and include the transmission of the fire signal. Results of the audit will be forwarded monthly to the Continuous Quality Improvement Committee for follow up and intervention. Monthly audits will be completed until there is 100 % compliance then annually thereafter. Education was provided to the Maintenance Director and support staff regarding fire drills to be conducted quarterly on each shift and to include transmission of the	05/22/2013

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			signal to the fire alarm signal company. IV. The Continuously Quality Review Committee will monitor the audits to ensure that all fire drills are conducted quarterly on each shift and to include transmission of the signal to fire alarm signal company. Audits will be complete until there is 100 % compliance, then quarterly thereafter. V. Completion date: May 22, 2013	

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K020144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 40 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply-TELS	K020144	**K 144 NFPA 101 Life Safety Code standard** I. A Generator test was conducted on 05.11.2013 which inspected for battery, electrolyte and oil levels and a complete written record is maintained with the generator log. II. The Director of Maintenance updated the test procedure to include battery, electrolyte and oil levels at intervals of not more than 7 days and shall be maintained in full compliance with the manufacturer's specifications and a complete written record is maintained with the generator log. III. The Director of Maintenance will submit Inspection records to the Continuous Quality Review Committee for batteries are used in connection with essential electrical systems will be inspected at intervals of not more than 7 days and a complete written record is maintained with the generator log. The Maintenance Director will report results of the audit to the Administrator or designee. Results of the audit will be reported in the monthly Continuously Quality Review Committee for further intervention and follow up. Monthly audits will be completed until there	05/22/2013

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	Logbook Documentation "Exercise Generator (with no load)" and "Test Generator Under Load" documentation with the Maintenance Director during record review from 9:10 a.m. to 10:45 a.m. on 04/22/13, weekly emergency generator starting battery inspection records for the forty week period of 07/20/12 through 04/19/13 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of weekly battery inspections after 07/13/12 was not available for review. 3.1-19(b)		is 100 % compliance then annually thereafter. Education was provided to the Maintenance Director and support staff regarding the test procedure and inspection of the generator as well as the logging of the battery, electrolyte and oil levels in the written record at intervals of not more than 7 days that are used in connections essential electrical systems. IV. The Continuously Quality Review Committee will monitor the audits to ensure that a complete written record of the inspections of batteries at intervals of not more than 7 days that are used in connections essential electrical systems. Completion date May 22, 2013	