

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155532	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/14/2014
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NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/14/14</p> <p>Facility Number: 000460 Provider Number: 155532 AIM Number: 100290620</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Bloomington Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated</p>	K010000	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 May 14, 2014 to the Life Safety survey conducted on April 14, 2014.	

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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K010046 SS=C	<p>smoke detectors in all resident sleeping rooms. The facility has a capacity of 38 and had a census of 33 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two detached sheds used for facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/22/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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 record review and interview, the facility failed to ensure the documentation for the testing of 12 of 12 battery powered light sets was complete when testing monthly for 30 seconds and annually for 90 minutes. LSC 101, Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An</p>	K010046	<p>K046 It is the practice ofBloomington Nursing & Rehab to ensure that emergency lighting is testedappropriately in accordance with the regulation <i>The corrective actions accomplished for those</i></p>	05/14/2014

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	<p>annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. 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. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the battery back up light form on 04/14/14 at 10:20 a.m. with the Maintenance Supervisor present, there was documentation to show the twelve battery back up light sets were tested monthly, however, the form did not indicate the test was for at least thirty seconds, furthermore, for the past twelve months the documentation showed each battery back up light set listed in a column type form with only the date and a pass/fail result listed on the top line across from the first unit with only a squiggly line under the date and pass/fail columns for the other eleven units listed. Also, there was no documentation to</p>		<p>residents found to have been affected by the deficient practice: There were no specific residents identified. However, the emergency lighting in the identified areas have been tested and verification documentation is in place.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions: Potentially all residents could be affected. Please refer to systems and means of monitoring below to prevent reoccurrence.</p> <p>What measures will be implemented or systemic changes will be made to ensure that the deficient practice does not recur: The preventive maintenance form utilized when testing the emergency lighting has been revised to include the amount of time the battery was tested. The Maintenance Director has been in-service related</p>				

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K010048 SS=F	show the twelve battery back up light sets were tested for ninety minutes annually within the past twelve months. The most recent ninety minute annual test was dated 01/02/13. This was confirmed by Maintenance Supervisor at the time of record review. Based on observation between 11:45 a.m. and 1:00 p.m. during a tour of the facility with the Maintenance Supervisor, all battery back up light sets did operate properly. 3-1.19(b) NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of		to the use of the new form and the protocol related to the testing of battery powered lighting. How the corrective actions will be monitored to ensure the deficient practice will not recur: The battery powered lighting is tested as part of preventive maintenance. With the revised form showing the length of time tested, all aspects of testing are now covered in accordance with the regulation. The Maintenance Director is responsible for assuring that the form is completed timely and accurately. The QA committee will review this Preventive Maintenance Form at the regularly scheduled Quality Assurance meetings with recommendations based on the outcomes of the forms. Date Certain: May 14, 2014		

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	<p>all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 33 of 33 residents to accurately address all life safety systems such as staff response to battery operated or single station smoke detectors in resident sleeping rooms, plus a system addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants in the event of an emergency.</p> <p>Findings include:</p> <p>Based on a review of Fire Policy and Procedure on 04/14/14 at 10:45 a.m. with the Maintenance Supervisor present, the Fire Policy and Procedure plan did not</p>	K010048	<p>K048</p> <p>It is the practice of Bloomington Nursing & Rehab to ensure that the Fire Policy includes pertinent information in accordance with theregulation.</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice:</p> <p>No specific residents were identified. The Fire Policy has been revised to include the pertinent information</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions:</p> <p>Potentially all residents could be affected. Please refer to systems and means of monitoring below to prevent reoccurrence.</p> <p>What measures will be implemented or systemic changes will be made to ensure that the deficient</p>	05/14/2014			

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K010050 SS=F	address staff response to battery operated smoke detectors in resident sleeping rooms. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the Fire Policy and Procedure plan was not a complete plan. 3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD		<i>practice does not recur:</i> The Fire Plan Policy has been revised to include staffresponse to battery operated smoke detectors in resident sleeping rooms. All staff has been in-serviced related to therevised policy. <i>How the corrective actions will be monitored to ensure thedeficient practice will not recur:</i> The policy has been revised to include the pertinent informationrelated to the battery operated smoke detectors. The Administrator isresponsible for assuring that the policies remain current and include pertinentinformation. The QA committee will reviewpolicies associated with Life Safety issues annually (or more often ifnecessary) at the Quality Assurance meetings with recommendations based on theoutcomes of any reviews. <i>Date Certain: May 14, 2014</i>		

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	<p>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</p> <p>Based on record review and interview, the facility failed to ensure written documentation on 8 of 13 fire drills was clear as far as times the drills were performed and when the monitoring company received the transmission of the fire alarm. LSC 19.7.1.2 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Life Safety book on 04/14/14 at 10:00 a.m. with the Maintenance Supervisor present, written documentation on the following fire drills was unclear and confusing as far as the times the drills were performed and when the monitoring company received the transmission of the fire alarm:</p> <p>a. 4/29/13 - fire drill at 6:06 p.m. and</p>	K010050	<p>K050</p> <p>It is the practice of Bloomington Nursing & Rehab to ensure that documentation on fire drills is complete and identifies all pertinent areas.</p> <p><i>The corrective actions accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>No specific residents were identified. Fire Drills are being documented with pertinent information in accordance with the regulation.</p> <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions:</i></p>	05/14/2014

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	<p>monitoring company received alarm at 1:06 (no date or a.m./p.m.)</p> <p>b. 5/19/13 - fire drill at 3:40 (unclear if a.m./p.m.) and no time documented when monitoring company received signal, only name and restore time</p> <p>c. 6/12/13 - fire drill at 8:00 p.m. and no information monitoring company received signal</p> <p>d. 8/19/13 - fire drill at 10:45 (no a.m./p.m.) and time monitoring company received signal was 3:46 (no a.m./p.m.) and signal restore at 1600</p> <p>e. 9/13/13 - fire drill at 3:50 a.m. and monitoring company received signal at 2:50 (no date or a.m./p.m.)</p> <p>f. 10/02/13 - fire drill at 6:30 a.m. and monitoring company received signal at 11:30 a.m.</p> <p>g. 11/25/13 - fire drill at 8 a.m. and monitoring company received signal at 5:00 (no date or a.m./p.m.)</p> <p>h. 12/17/13 - fire drill at 12:45 (unclear a.m./p.m.) and no information monitoring company received signal</p> <p>This was acknowledged by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b)</p>		<p>Potentially all residents could be affected. Please see below for system changes and means of monitoring.</p> <p><i>What measures will be implemented or systemic changes will be made to ensure that the deficient practice does not recur:</i></p> <p>The Maintenance Director has been in-serviced related to the use of the form and the protocol related to the documentation of fire drills. The Maintenance Director will also be turning the forms in for review to the Administrator prior to being filed.</p> <p><i>How the corrective actions will be monitored to ensure the deficient practice will not recur:</i></p> <p>The fire drills with complete documentation are the responsibility of the Maintenance Director. With review by the Administrator, we believe that all documentation will be accurate and thorough. The QA committee will</p>				

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K010103 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure all framing of interior ceiling and partitions was constructed of noncombustible or limited combustible materials in 1 of 3 smoke compartments in accordance with the requirements of NFPA 101 2000 edition, section 19.1.6.3. This deficient practice could affect all residents while in the dining room and front lobby area.</p> <p>Findings include:</p> <p>Based on observation on 04/14/14 at 12:35 p.m. during a tour of the facility with the Maintenance Supervisor, the framing of the closet walls around the sprinkler riser was constructed of wood two by fours. The facility was Type II construction which is a noncombustible type of construction. Framing of walls in</p>	K010103	<p>review this fire drill documentation at the regularly scheduled Quality Assurance meetings with recommendations based on the outcomes of the forms. Date Certain: May 14, 2014</p> <p>K103 It is the practice of Bloomington Nursing & Rehab to ensure that interior walls and partitions in building of Type I or Type II construction are noncombustible or limited-combustible materials. The corrective actions accomplished for those residents found to have been affected by the deficient practice: The framing of the closet walls around the sprinkler riser has been replaced with metal noncombustible studs.</p>	05/14/2014	

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	<p>a building of noncombustible construction are required to be of noncombustible or limited combustible materials. Untreated wood without a fire rating is not an acceptable wall framing material in a noncombustible building. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions:</p> <p>All other facility areas have been reviewed and no additional findings were identified.</p> <p>What measures will be implemented or systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The Maintenance Director has been in-serviced related to the proper materials to be utilized related to non-combustible materials. The Maintenance Director is responsible for assuring that all framing is in accordance with the fire/safety guidelines.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>The Maintenance Director is responsible for assuring that only appropriate materials will be utilized in</p>	

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K010130 SS=F	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to document the maintenance of 33 of 33 battery operated smoke detectors in all resident rooms plus other rooms and areas to ensure the smoke detectors are continually operable. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. This deficient practice could affect all residents, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation on 04/14/14 between 11:45 a.m. and 1:00 p.m. during a tour of the facility with the Maintenance Supervisor, battery operated smoke detectors were observed in all</p>	K010130	<p>accordance with theregulation. As Maintenance Directormakes rounds, he will include assuring that the proper noncombustible materialsare in place. Any areas identified willbe corrected immediately. <i>Date Certain: May 14, 2014</i></p> <p>K130 It is the practice ofBloomington Nursing & Rehab to ensure that battery operated smoke detectorsis checked routinely as part of preventive maintenance. <i>The corrective actions accomplished for those residents foundto have been affected by the deficient practice:</i> All smoke detectors have been checked to assure operatingproperly <i>How other residents having the potential to be affected bythe same deficient practice will be identified and what</i></p>	05/14/2014

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	<p>resident sleeping rooms as well as other rooms and areas throughout the facility. Based on interview during record review on 04/14/14 at 11:15 a.m. the Maintenance Supervisor said, the facility utilizes battery operated smoke detectors in all resident sleeping rooms as well as other rooms and areas throughout the facility. Furthermore, the Maintenance Supervisor said only a few of the batteries in the battery operated smoke detectors had been changed since he started as the Maintenance Supervisor in January of 2014, and those were changed because the smoke detectors started to beep due to dead batteries, but no documentation was available to show which of those smoke detectors had been changed. The Maintenance Supervisor also said there was no documentation to show all smoke detectors had been tested monthly during the past twelve months, and, there was no documentation available to show the batteries in the smoke detectors had been changed within the past twelve months.</p> <p>3.1-19(b)</p>		<p>corrective actions: Potentially all residents could be affected. Please see system below and means of monitoring. What measures will be implemented or systemic changes will be made to ensure that the deficient practice does not recur: The checking of battery operated smoke detectors has been added to the preventive maintenance tracking. The Maintenance Director has been in-serviced related to assuring that battery operated smoke detectors monthly in accordance with the regulations. How the corrective actions will be monitored to ensure the deficient practice will not recur: The monthly testing documentation of the battery operated smoke detectors is the responsibility of the Maintenance Director to be completed. The form will be reviewed by the QA committee at the regularly</p>		

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K010147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure multiplug adapters were not used as a substitute for fixed wiring in 1 of 18 resident rooms. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 2 residents in resident room 17.</p> <p>Findings include:</p> <p>Based on observation on 04/14/14 at 12:05 p.m. during a tour of the facility with the Maintenance Supervisor, resident room 17 had a small refrigerator and oxygen concentrator plugged into a multiplug adapter which was plugged</p>	K010147	<p>scheduled meetings with recommendations as needed based on the outcome of the form. Date Certain: May 14, 2014</p> <p>K147 It is the practice of Bloomington Nursing & Rehab to ensure that multi-plug adaptors are not utilized in place of wiring. The corrective actions accomplished for those residents found to have been affected by the deficient practice: The multi-plug adaptor in room #17 has been removed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions: All resident rooms have been reviewed to assure that no multi-plug adaptors</p>	05/14/2014			

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K010154 SS=C	into the wall outlet. At the time of each observation, the Maintenance Supervisor acknowledged the use of the multiplug adapter and said he didn't know it was being used in the room. 3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler		are in place. What measures will be implemented or systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director has been in-serviced related to proper electrical use of equipment including proper plug-in capability. The Maintenance Director is responsible for assuring that multi-plug adaptors are not utilized in the resident rooms. How the corrective actions will be monitored to ensure the deficient practice will not recur: The Maintenance Director is responsible for assuring that multi-plug adaptors are not utilized in the resident rooms. The Maintenance Director as well as the Administrator will be making rounds each business day to assure that this practice is corrected. Date Certain: May 14, 2014		

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	<p>system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 33 of 33 residents containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of a sprinkler impairment and 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 in the facility.</p> <p>Findings include:</p> <p>Based on review of the Fire Watch policy on 04/14/14 at 10:30 a.m. with the Maintenance Supervisor present, the</p>	K010154	<p>K154</p> <p>It is the practice ofBloomington Nursing & Rehab to ensure that the policy is inclusive of allpertinent information in accordance with the regulation.</p> <p>The corrective actions accomplished for those residents foundto have been affected by the deficient practice:</p> <p>No specific residents were identified. The Fire Policy has been revised to includethe pertinent information</p> <p>How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective actions:</p> <p>Potentially all residents could be affected. Please refer to systemic changes</p>	05/14/2014

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K010155 SS=C	<p>facility did have a written policy and procedure for an impaired fire protection system which was revised in 2008 and again in 2010. Both stated under "Guidelines" (#6 for the 2008 policy, and #3 for the 2010 policy) "If the corrective action will take more than 4 hours, do the following:". They did not include the "out of service for 4 hours or more in a 24 hour period" statement. The 2008 policy did include the correct phone numbers for the local fire department and the Indiana State Department of Health, however, the 2010 policy did not include the local fire department phone number, plus the phone number listed for the Indiana State Department of Health was directly to the Life Safety Code section and not the 24 hour unusual occurrence number. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the discrepancies between the two revised Fire Watch policies, furthermore, the Maintenance Supervisor was unsure which policy was to be followed.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		<p>and means of monitoring. What measures will be implemented or systemic changes will be made to ensure that the deficient practice does not recur: The Fire Plan Policy has been revised to include "out of service for 4 hours or more in a 24 hour period" in accordance with the regulation. All staff has been in-serviced related to the revised policy. How the corrective actions will be monitored to ensure the deficient practice will not recur: Administrator is responsible for assuring that the policies remain current and include pertinent information. The QA committee will review policies associated with Life Safety issues annually (or more often if necessary) at the Quality Assurance meetings with recommendations based on the outcomes of the reviews. Date Certain: May 14, 2014</p>		

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	<p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 33 of 33 residents containing procedures to be followed in the event the fire alarm system has to be placed out of services for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all occupants in the facility including residents, staff, and visitors.</p>	K010155	<p>K155</p> <p>It is the practice of Bloomington Nursing & Rehab to ensure that our policy includes information related to procedures to follow if the fire alarm system is out of service for more than 4 hours in a 24 hour period.</p> <p><i>The corrective actions accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>No specific residents were identified. The Fire Watch Policy has been revised to include the pertinent information</p> <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions:</i></p> <p>Potentially all residents</p>	05/14/2014

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	<p>Findings include:</p> <p>Based on review of the Fire Watch policy on 04/14/14 at 10:30 a.m. with the Maintenance Supervisor present, the facility did have a written policy and procedure for an impaired fire protection system which was revised in 2008 and again in 2010. Both stated under "Guidelines" (#6 for the 2008 policy, and #3 for the 2010 policy) "If the corrective action will take more than 4 hours, do the following:". They did not include the "out of service for 4 hours or more in a 24 hour period" statement. The 2008 policy did include the correct phone numbers for the local fire department and the Indiana State Department of Health, however, the 2010 policy did not include the local fire department phone number, plus the phone number listed for the Indiana State Department of Health was directly to the Life Safety Code section and not the 24 hour unusual occurrence number. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the discrepancies between the two revised Fire Watch policies, furthermore, the Maintenance Supervisor was unsure which policy was to be followed.</p> <p>3.1-19(b)</p>		<p>could be affected. Please see systems and means of monitoring below.</p> <p>What measures will be implemented or systemic changes will be made to ensure that the deficient practice does not recur: The Fire Watch Policy has been revised to include "out of service for 4 hours or more in a 24 hour period" statement in accordance with the regulation. All staff has been in-service related to the revised policy.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: Administrator is responsible for assuring that the policies remain current and include pertinent information. The QA committee will review policies associated with Life Safety issues annually (or more often if necessary) at the Quality Assurance meetings with recommendations based on the outcomes of the reviews</p>	

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