

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155768	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 06/10/2013
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NAME OF PROVIDER OR SUPPLIER EVANSVILLE PROTESTANT HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3701 WASHINGTON AVE EVANSVILLE, IN 47714
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K020000	<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: 06/10/13</p> <p>Facility Number: 001125 Provider Number: 155768 AIM Number: NA</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Evansville Protestant Home, Inc. was found not in compliance with Requirements for Participation in Medicare 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 facility consists of two buildings connected by a service corridor. The north building is a one story facility with a basement determined to be of Type II (000) and fully sprinklered. The south building is a one story facility determined to be of Type II (000) and fully</p>	K020000	<p>Life Safety Code Survey 2013</p> <p>Life Safety Code plan of correction is respectfully submitted to the Indiana State Department of Health. The preparation and or execution of this plan of correction or any other correction set forth herein does not constitute and admission or agreement by the Evansville Protestant Home of the facts alleged or in conclusions set forth in the statement of deficiencies. The plan of correction and specific actions are solely executed for provisions by federal and state law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>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 smoke detectors in all resident sleeping rooms. The facility has a capacity of 68 and had a census of 56 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except one detached wood framed storage shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/14/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K020011 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 fire barriers to a nonconforming building was protected by a two hour fire wall. This deficient practice could affect 9 residents, as well as staff and visitors in the North Unit, east-west corridor.</p> <p>Findings include:</p> <p>Based on observation on 06/10/13 at 12:30 p.m. during a tour of the facility with the Environmental Director, the fire wall directly above the set of fire doors between the North Unit east-west corridor and the north Residential apartments unit had a two foot by four foot door opening. The door was wide open and was not provided with a self closer, plus, the door was not provided with a latching device. There was a four inch sprinkler pipe running through the lower portion of the door opening as well as two large wire bundles which prevented the door from closing completely. When the door was closed as far as it would go there was a</p>	K020011	<p>K011</p> <p>The fire wall has a door in place for access to other areas of the attic. The door will have a spring closure added and latch attached to ensure closure when someone is not actively walking through the door. The lower portion of the door will be dry walled up to make the door smaller and frame in the large bundle wires. Fire caulking shall complete this area. Other fire walls of the facility shall be reviewed by maintenance director or designee for penetrations. Maintenance shall provide report to Quarterly Assurance on a quarterly basis to ensure compliance. Completion date 7-10-13</p>	07/10/2013			

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	<p>four inch gap around the sprinkler pipe. Furthermore, there were six foot to eight foot wedged sections not protected with a two hour fire wall on both sides where the roof met the ceiling. There was only exposed lathe and plaster. This was acknowledged by the Environmental Director at the time of observation.</p> <p>3.1-19(b)</p>			

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K020020 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 vertical opening doors between floors was provided with a tag to prove at least a one hour fire resistance rating. This deficient practice could affect up to 17 residents, as well as staff and visitors in the North Unit north-south corridor.</p> <p>Findings include:</p> <p>Based on observation on 06/10/13 at 1:40 p.m. during a tour of the facility with the Environmental Director, the basement access door from the first floor was not provided with fire rating tag. This was confirmed by the Environmental Director at the time of observation.</p> <p>3.1-19(b)</p>	K020020	K020 The north unit basement access door shall be reviewed by specialty vendor. Fire rating was unable to be determined. A new 90-minute door shall be approved and ordered.	07/10/2013			

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K020021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 vertical opening doors was only held open by a device which would allow the door to close upon activation of the fire alarm system. This deficient practice could affect up to 17 residents, as well as staff and visitors in the North Unit north-south corridor, plus staff while in the basement.</p> <p>Findings include:</p> <p>Based on observation on 06/10/13 at 1:45 p.m. during a tour of the facility with the Environmental Director, the first floor access door from the basement was held wide open with a metal kickstand attached to the bottom of the door which would not allow the door to close if the fire alarm system was activated.</p>	K020021	<p>K021 The first floor access door from the basement has had the metal kickstand removed from the bottom of door.</p>	07/10/2013			

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	<p>Furthermore, the sign on the door said "Fire Door Keep Closed." This was acknowledged by the Environmental Director at the time of observation.</p> <p>3.1-19(b)</p>			

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K020025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 smoke barrier walls provided at least a one half hour fire resistance rating. This deficient practice could affect up to 26 residents, as well as staff and visitors in the North Unit.</p> <p>Findings include:</p> <p>Based on observation on 06/10/13 at 12:45 p.m. during a tour of the facility with the Environmental Director, the smoke barrier wall above the smoke barrier doors between the North Unit east-west corridor and the connecting North Unit north-south corridor had a three foot by four foot opening through the wall. The Environmental Director acknowledged the opening in the smoke barrier wall and said it must have been knocked out when the attic insulation was installed within the last couple of years.</p>	K020025	<p>K025 Smoke barrier wall shall have the 5/8 inch dry wall redone and fire caulked for proper sealing. Other smoke walls of the facility shall be reviewed by maintenance director or designee for penetrations. Maintenance shall provide report to Quarterly Assurance on a quarterly basis to ensure compliance. Completion date 7-10-13</p>	07/10/2013			

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K020029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 sets of laundry room double doors, hazardous area doors, to the corridor connecting the north and south units, were equipped with positive latches and latched into their door frames. This deficient practice could affect mostly staff plus any number of residents traversing the connecting corridor.</p> <p>Findings include:</p> <p>Based on observation on 06/10/13 at 2:10 p.m. during a tour of the facility with the Environmental Director, the two sets of double doors from the corridor into the laundry room would not latch into their door frames. This was acknowledged by the Environmental Director at the time of observation.</p>	K020029	<p>K029 The laundry room doors in the corridor shall have the head bar electrified to force the latches into the door frames when it closes. Electrician shall review for power supply issues. The doors shall still function with the push button if electrician able to locate problem. If electrician unable to detect then actuators will be disabled.</p>	07/10/2013			

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K020040 SS=B	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5</p> <p>Based observation and interview, the facility failed to ensure sleeping room exit doors were at least 32 inches wide for 29 of 52 resident sleeping room doors. This deficient practice could affect 26 residents in the North Unit.</p> <p>Findings include:</p> <p>Based on observation on 06/10/13 between 1:00 p.m. and 2:00 p.m. during a tour of the facility with the Environmental Director, the following resident sleeping room door openings in the North Unit measured only 31 and 1/4 inches: Rooms 1 through 18, 20, 22, 24, 25, 26, 27, 29, and 30. This was confirmed by the Environmental Director who measured the door openings.</p> <p>3.1-19(b)</p>	K020040	K040 Annual Waiver Request Provider # 155768See Attachments for additional information	07/10/2013			

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K020062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure only one type of sprinkler head, i.e., quick response or standard sprinklers, were installed in a compartmented space in 1 of 6 smoke compartments. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a smoke compartment shall be changed. This deficient practice could affect 30 residents in the South Unit.</p> <p>Findings include:</p> <p>Based on observation on 06/10/13 at 10:00 a.m. during a tour of the facility with the Environmental Director, there were two quick response sprinkler heads mixed with standard response sprinkler heads in the South Unit corridor outside the Clean Closet. This was acknowledged by the Environmental Director at the time of observation.</p> <p>3.1-19(b)</p>	K020062	<p>K062 1. On 6-13-13 Tri-State Fire Protection replaced the two quick response pendants in the South Unit corridor with standard 155 degree pendants, the same as the other pendants on the unit.2. The light fixture at the North Nurse's station has been moved to allow the sprinkler head to function properly. Maintenance Director shall conduct audit in skilled facility area to determine if any additional changes need to be made.3. On 6-13-13, the sprinkler head located in the closet of the orientation room was placed in proper orientation by Tri State Fire Protection.4. On 6-13-13, Tri State Fire Protection added four 155 standard horizontal sidewall sprinkler heads to the cabinet located in the maintenance office.</p>	07/10/2013			

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	<p>2. Based on observation and interview, the facility failed to ensure 2 of over 500 sprinkler heads in the facility were free of obstructions to the spray pattern. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Furthermore NFPA 13, Installation of Sprinkler Systems, 4-5.51.1 requires sprinklers shall be located as to minimize obstructions to discharge. This deficient practice could affect maintenance staff and up to 17 residents as well as staff and visitors in the North Unit north-south corridor.</p> <p>Findings include:</p> <p>Based on observations on 06/10/13 between 11:45 a.m. and 2:45 p.m. during a tour of the facility with the Environmental Director, the pendant sprinkler head in the Maintenance Office was within one inch of the light fixture, furthermore, the pendant sprinkler head at the North Unit Nurses' Station was within one inch of the light fixture. The spray pattern of both sprinkler heads would be restricted in the event the sprinkler heads were actuated. This was acknowledged by the Environmental Director at the time of each observation.</p> <p>3.1-19(b)</p>				

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	<p>3. Based on observation and interview, the facility failed to ensure 1 of over 400 sprinkler heads was in the proper orientation (upright, pendent, or sidewall). NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be in the proper orientation (upright, pendent, or sidewall). Any sprinkler shall be replaced that is in the improper orientation. This deficient practice could affect staff and visitors while in the basement Admissions Office.</p> <p>Findings include:</p> <p>Based on observation on 06/10/13 at 1:50 p.m. during a tour of the facility with Environmental Director, the sprinkler head in the basement Admissions Office was an upright sprinkler head installed on the bottom of the sprinkler pipe instead of a pendent type sprinkler head. This was acknowledged by the Environmental Director at the time of observation.</p> <p>3.1-19(b)</p> <p>4. Based on observation and interview, the facility failed to ensure 2 of 2 automatic sprinkler head storage cabinets were provided with at least two of each type of sprinkler head used in the facility.</p>			

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	<p>NFPA 25, 2-4.1.4 requires a minimum of two sprinklers of each type and temperature rating installed shall be stored in a cabinet on the premises for replacement purposes. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 06/10/13 between 12:15 p.m. and 2:45 p.m. during a tour of the facility with the Environmental Director, the two spare sprinkler head cabinets in the facility had more than six spare sprinkler heads each, but, did not include sidewall sprinkler heads. The remaining sprinkler heads were a mixture of other pendent type sprinkler heads and upright type sprinkler heads. Sidewall sprinkler heads were observed in the basement Orientation room during the tour. This was acknowledged by the Environmental Director at the time of observations, furthermore, the Environmental Director indicated there were no other spare sprinkler heads in the facility.</p> <p>3-1.19(b)</p>				

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(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			
K020154 SS=C	<p>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 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 56 of 56 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 at the time of this survey.</p> <p>Findings include:</p> <p>Based on review of the Emergency</p>	K020154	<p>K154 The written policy has been updated to read as follows: Procedure:</p> <p>1.A fire watch shall be established in the facility when the fire alarm and/or smoke alarm system is temporarily shut down more than 4 hours in a 24 hour period, for reasons including maintenance, periodic inspection, renovation, or demolition work. The areas that are affected by the outage or malfunction will be covered until the system has been repaired, tested, and placed back into service. When a fire watch is established it may be considered an unusual occurrence which is required to be reported to the Indiana State Department of Health. The direct number for an unusual occurrence is 317-233-7322. It is customary to fax a report which is sent to 317-233-7494. The fax report is completed by the Administrator, Director of Nursing, or designee. It is required to report our system temporarily shut down to the local fire department to the non</p>	07/10/2013			

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	<p>Manual on 06/10/13 at 10:45 a.m., the facility did have a written policy and procedure for an impaired fire protection system, however, the fire watch policy and procedure did not include information to contact the local fire department and the local fire department phone number. The lack of this documentation was acknowledge by the Environmental Director at the time of record review.</p> <p>3.1-19(b)</p>		<p>emergent number 812-435-6235 during business hours and 911 to report the non emergent situation after 4pm daily and on weekends. EPH insurance agent Dan Kincaid is to be notified at 812-649-5739. Please contact the Maintenance Director and Nurse on call for any additional direction needed and to ensure all procedures are being followed.</p> <p>2.The fire watch will be manned by someone who does not have another immediate job duty in the facility. Example, an employee may perform the fire watch but they can not also be responsible for patient care or cooking a meal during the fire watch period.</p> <p>3.A written log will be maintained, it is labeled fire watch. The log will contain date, time, name of person conducting fire watch, and the status of the alarm.</p> <p>4.Contractors shall be responsible for conducting fire watches for impairments caused by construction work.</p> <p>5.A thorough inspection of all common areas, mechanical/electrical/boiler rooms, storage rooms, kitchen, laundry, resident room and other high risk area must be conducted at 15 minute increments for affected areas of the facility. <u>To report a fire call 911 immediately and provide the facility address of 3701 Washington Avenue.</u></p> <p>6.A fire watch has only been completed when the system has</p>		

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			<p>been repaired, tested, and placed back into service. <u>Our monitoring company Vanguard must be contacted to confirm we are on line at 424-9574. The facility code is #2064.</u></p> <p>7. Questions about this policy should be directed to the Maintenance Director, Administrator, or other Department Supervisor.</p>		

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K020155 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 56 of 56 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</p>	K020155	<p>K155The written policy has been updated to read as follows: Procedure: 1.A fire watch shall be established in the facility when the fire alarm and/or smoke alarm system is temporarily shut down more than 4 hours in a 24 hour period, for reasons including maintenance, periodic inspection, renovation, or demolition work. The areas that are affected by the outage or malfunction will be covered until the system has been repaired, tested, and placed back into service. When a fire watch is established it may be considered an unusual occurrence which is required to be reported to the Indiana State Department of Health. The direct number for an unusual occurrence is 317-233-7322. It is customary to fax a report which is sent to 317-233-7494. The fax report is completed by the Administrator, Director of Nursing, or designee. It is required to report our system temporarily shut down to the local fire department to the non emergent number 812-435-6235 during business hours</p>	07/10/2013			

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	<p>including residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of the Emergency Manual on 06/10/13 at 10:45 a.m., the facility did have a written policy and procedure for an impaired fire protection system, however, the fire watch policy and procedure did not include information to contact the local fire department and the local fire department phone number. The lack of this documentation was acknowledge by the Environmental Director at the time of record review.</p> <p>3.1-19(b)</p>		<p>and 911 to report the non emergent situation after 4pm daily and on weekends. EPH insurance agent Dan Kincaid is to be notified at 812-649-5739. Please contact the Maintenance Director and Nurse on call for any additional direction needed and to ensure all procedures are being followed.</p> <p>2.The fire watch will be manned by someone who does not have another immediate job duty in the facility. Example, an employee may perform the fire watch but they can not also be responsible for patient care or cooking a meal during the fire watch period.</p> <p>3.A written log will be maintained, it is labeled fire watch. The log will contain date, time, name of person conducting fire watch, and the status of the alarm.</p> <p>4.Contractors shall be responsible for conducting fire watches for impairments caused by construction work.</p> <p>5.A thorough inspection of all common areas, mechanical/electrical/boiler rooms, storage rooms, kitchen, laundry, resident room and other high risk area must be conducted at 15 minute increments for affected areas of the facility. <u>To report a fire call 911 immediately and provide the facility address of 3701 Washington Avenue.</u></p> <p>6.A fire watch has only been completed when the system has</p>		

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			<p>been repaired, tested, and placed back into service. <u>Our monitoring company Vanguard must be contacted to confirm we are on line at 424-9574. The facility code is #2064.</u></p> <p>7. Questions about this policy should be directed to the Maintenance Director, Administrator, or other Department Supervisor.</p>	