

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2014
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NAME OF PROVIDER OR SUPPLIER HOOSIER VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268
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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: 06/03/14</p> <p>Facility Number: 000548 Provider Number: 155472 AIM Number: NA</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hoosier Village 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) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in resident sleeping rooms, in support rooms and at smoke barrier and</p>	K010000	The plan of correction constitutes the written compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by the state and federal law.	
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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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K010018 SS=D	<p>horizontal exit doors. The facility has a capacity of 122 and had a census of 65 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has no detached buildings providing facility services.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/09/14.</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 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p>						

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	<p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of over 75 corridor doors had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 10 staff and visitors in the vicinity of the Laundry.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services during a tour of the facility from 1:00 p.m. to 3:45 p.m. on 06/03/14, the corridor door to the clean room side of the Laundry was propped in the fully open position with a wedge which provided an impediment to closing and latching and it failed to resist the passage of smoke. Based on interview at the time of observation, the Director of Environmental Services acknowledged the corridor door to the clean room side of the Laundry was propped in the fully open position with a wedge which provided an impediment to closing and latching and would fail to resist the passage of smoke.</p> <p>3.1-19(b)</p>	K010018	The door wedge to the clean side of the laundry room was removed immediately so that the door was able to close and latch securely. There were no other doors that a wedge was used to prop open and therefore no residents adversely affected. To ensure ongoing compliance the laundry staff were re-trained on keeping the door free from door props and wedges on 6/6/14. As a means of quality assurance the housekeeping supervisor will conduct visual audits on a weekly basis to ensure that the door is not being wedged open. Audits will be shared with the Safety committee quarterly.	06/13/2014			

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K010025 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 1 ceiling smoke barriers was protected to maintain the fire resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Main Mechanical Room by Physical Therapy.</p>	K010025	<p>The 3 openings noted in the ceiling of the main mechanical room were remedied by filling the areas around the cable with a material capable of maintaining the smoke resistance by in house maintenance staff. Work was completed on 6/19/14. No residents were adversely affected. To ensure ongoing compliance any future penetration of the smoke barrier walls will be remedied at the time of penetration. As a means of quality assurance a quarterly inspection of all smoke and fire barrier walls will be performed by in house maintenance staff with results presented to the safety committee quarterly on an ongoing basis.</p>	06/20/2014
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	<p>Findings include:</p> <p>Based on observations with the Director of Environmental Services during a tour of the facility from 1:00 p.m. to 3:45 p.m. on 06/03/14, the following openings were noted in the ceiling of the Main Mechanical Room:</p> <ul style="list-style-type: none"> a. a one and a half inch in diameter hole for the passage of three cables above the electrical panel by the transfer switch. b. a one inch in diameter hole for the passage of one cable above the transfer switch. c. a ten inch in diameter hole above a water heater and an eighteen inch by ten inch hole above a second water heater were noted which each exposed the attic above. <p>Based on interview at the time of the observations, the Director of Environmental Services acknowledged the aforementioned openings failed to maintain the smoke resistance of the ceiling smoke barrier.</p> <p>3.1-19(b)</p>			
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K010029 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 1 of 22 hazardous areas such as laundries greater than 100 square feet were separated from other areas by smoke resistant partitions. This deficient practice could affect 10 staff and visitors in the vicinity of the Laundry.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services during a tour of the facility from 1:00 p.m. to 3:45 p.m. on 06/03/14, the corridor door to the clean room side of the Laundry for the facility was propped in the fully open position with a wedge which failed to separate the Laundry from other areas by smoke resistant partitions. Based on interview at the time of observation, the Director of Environmental Services</p>	K010029	The door wedge to the clean side of the laundry room was removed immediately so that self-closing mechanism would keep the door latched and provided a smoke resistant partition. There were no other doors that were open using a wedge and therefore no residents affected. To ensure ongoing compliance the laundry staff were re-trained on keeping the door free from door wedges or props on 6/6/14. As a means of quality assurance the housekeeping supervisor will conduct audits on a weekly basis to ensure that the door is not being wedged open. Audits will be shared with the safety committee quarterly.	06/13/2014	

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K010038 SS=E	<p>acknowledged the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions.</p> <p>3.1-19(b)</p> <p>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 were 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 which 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</p>	K010038	A sign has been placed above the key pad with the code to the door. As this is the only door that has a key pad in the health center, there were no other doors affected. To ensure ongoing compliance, the facility administrator will ensure that the code to the door is posted at the key pad on an ongoing basis. As a means of quality assurance, the administrator will review the code posting with the safety committee quarterly.	06/20/2014

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K010050 SS=F	<p>unlock such doors at all times. This deficient practice could affect 10 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services during a tour of the facility from 1:00 p.m. to 3:45 p.m. on 06/03/14, the exit to Deercrest Hall was marked as a facility exit, the exit door was magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of observation, the Director of Environmental Services stated not all residents have a clinical diagnosis to be in a secure building and acknowledged the four digit code was not posted at the exit to Deercrest Hall. 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.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times</p>			

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	<p>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>1. Based on record review and interview, the facility failed to document activation of the fire alarm system for second shift fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Check Sheet" documentation with the Director of Environmental Services during record review from 9:25 a.m. to 12:00 p.m. on 06/03/14, documentation for the second shift fire drill conducted on 05/19/14 at 3:00 p.m. indicated the drill was</p>	K010050	The facility will conduct fire drills at unexpected times, under varying conditions and at least quarterly on each shift. No residents were adversely affected. To ensure ongoing compliance fire drills schedule has been revised to ensure fire drills are conducted at random times on each shift and the alarm is activated for all fire drills conducted on the 2nd shift if the drill is conducted before 9pm. The schedule will be reviewed by the Environmental Services supervisor quarterly. Fire drills will be logged and will be reviewed with the life safety committee on a quarterly basis.	06/27/2014

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	<p>conducted after 6:00 a.m. but before 9:00 p.m. and did not include activation of the fire alarm system and transmission of the fire alarm signal. Documentation for the aforementioned fire drill stated it was a "Silent drill." Based on interview at the time of record review, the Director of Environmental Services acknowledged the second shift fire drill conducted on 05/19/14 at 3:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to completely document fire drills conducted on the first shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Check Sheet" documentation with the Director of Environmental Services during record review from 9:25 a.m. to 12:00 p.m. on 06/03/14, documentation for the first shift fire drill conducted on 01/28/14 stated the drill was conducted on the first shift but did not include the time of day the drill was conducted. Based on interview at the time of record review,</p>			

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	<p>the Director of Environmental Services acknowledged the aforementioned first shift fire drill documentation did include the time of day the fire drill was conducted.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Check Sheet" documentation with the Director of Environmental Services during record review from 9:25 a.m. to 12:00 p.m. on 06/03/14, third shift fire drills conducted on 05/22/13, 11/18/13 and 03/03/14 were each conducted at 12:00 a.m. Based on interview at the time of record review, the Director of Environmental Services acknowledged the aforementioned third shift fire drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p>			

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K010062 SS=D	<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>Based on observation and interview, the facility failed to replace 2 of over 100 sprinklers in the facility which had become corroded, had paint, lint or other foreign materials on them. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 2 staff and visitors in the Laundry.</p> <p>Findings include:</p>	K010062	The 2 sprinklers located behind the dryers in the laundry room that had lint were cleaned on 6/19/14. There were no residents adversely affected. To ensure ongoing compliance in house maintenance has performed a walk through to identify any sprinkler heads that have become corroded, had paint or lint on them. There were no other sprinklers affected. As a means of quality assurance, the maintenance staff will perform annual inspections of the sprinklers, results of the in house inspections will be reviewed with the Safety committee quarterly on an ongoing basis.	06/20/2014

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K010069 SS=D	<p>Based on observation with the Director of Environmental Services during a tour of the facility from 1:00 p.m. to 3:45 p.m. on 06/03/14, the two automatic sprinklers located behind the dryers in the Laundry were covered with lint. Based on interview at the time of observation, the Director of Environmental Services acknowledged the aforementioned automatic sprinklers were covered with lint.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 1. Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1999 edition, Section 8-2 requires an</p>	K010069	The health center kitchen hood extinguishing system is scheduled to be inspected and serviced on 6/20/14 by a contract company, Koorsen. The facility confirmed that the kitchen exhaust system was inspected and cleaned January of 2014 and semi-annual cleaning to be done again in June by Koorsen. To	07/01/2014

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	<p>inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect five staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire & Security "Restaurant Systems Work Order" documentation dated 09/17/13 with the Director of Environmental Services during record review from 9:25 a.m. to 12:00 p.m. on 06/03/14, documentation of semiannual hood extinguishing systems inspection six months after 09/17/13 was not available for review. Based on interview at the time of record review, the Director of Environmental Services acknowledged documentation of semiannual hood extinguishing systems inspection six months after 09/17/13 was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the</p>		<p>ensure ongoing compliance, the facility has set-up a routine semi-annual schedule with the contract company, Koorsen for both the hood extinguishing system and the kitchen exhaust system. As a means of quality assurance, the Director of Environmental services or his designee will review the semi-annual inspections and cleaning of the extinguishing and exhaust systems with the Safety Committee on a quarterly basis.</p>	

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	<p>entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect five staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on review of Grease Cutters "Kitchen Exhaust Systems Cleaning Work Order" documentation dated 06/20/13 with the Director of Environmental Services during record review from 9:25 a.m. to 12:00 p.m. on 06/03/14, documentation of a semiannual</p>			

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K020000	<p>kitchen exhaust system inspection six months after 06/20/13 was not available for review. Based on observation with the Director of Environmental Services during a tour of the facility from 1:00 p.m. to 3:45 p.m. on 06/03/14, a sticker was affixed to the kitchen range hood indicating a hood inspection was performed in January but the sticker did not state the year in which the January cleaning was performed. Based on interview at the time of record review and of the observation, the Director of Environmental Services stated it could not be assured a semiannual kitchen hood system inspection was performed in January 2014 and acknowledged documentation of semiannual kitchen exhaust systems inspection six months after 06/20/13 was not available for review.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by</p>	K020000	The plan of correction constitutes the written compliance for the	

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	<p>the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/03/14</p> <p>Facility Number: 000548 Provider Number: 155472 AIM Number: NA</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hoosier Village 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) and 410 IAC 16.2. The nurses station near resident Room 127 and Room 128 was constructed in 2010 and was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>The 2010 addition to the one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in resident sleeping rooms, in support rooms and at smoke barrier and horizontal exit doors. The facility has a capacity of 122 and had a census of 65 at</p>		<p>deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by the state and federal law.</p>	

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K020050 SS=F	<p>the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has no detached buildings providing facility services.</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 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</p> <p>1. Based on record review and interview, the facility failed to document activation of the fire alarm system for second shift fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00</p>	K020050	The facility will conduct fire drills at unexpected times, under varying conditions and at least quarterly on each shift. No residents were adversely affected. To ensure ongoing compliance fire drills schedule has been revised to ensure fire drills are conducted at random times on each shift and the alarm is activated for all fire drills conducted on the 2nd shift if the drill is conducted before 9pm. The schedule	06/27/2014

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	<p>p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Check Sheet" documentation with the Director of Environmental Services during record review from 9:25 a.m. to 12:00 p.m. on 06/03/14, documentation for the second shift fire drill conducted on 05/19/14 at 3:00 p.m. indicated the drill was conducted after 6:00 a.m. but before 9:00 p.m. and did not include activation of the fire alarm system and transmission of the fire alarm signal. Documentation for the aforementioned fire drill stated it was a "Silent drill." Based on interview at the time of record review, the Director of Environmental Services acknowledged the second shift fire drill conducted on 05/19/14 at 3:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to completely document fire drills conducted on the first shift for</p>		will be reviewed by the Environmental Services supervisor quarterly. Fire drills will be logged and will be reviewed with the life safety committee on a quarterly basis.	

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	<p>1 of 4 quarters. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Check Sheet" documentation with the Director of Environmental Services during record review from 9:25 a.m. to 12:00 p.m. on 06/03/14, documentation for the first shift fire drill conducted on 01/28/14 stated the drill was conducted on the first shift but did not include the time of day the drill was conducted. Based on interview at the time of record review, the Director of Environmental Services acknowledged the aforementioned first shift fire drill documentation did include the time of day the fire drill was conducted.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p>				

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	<p>Based on review of "Fire Drill Check Sheet" documentation with the Director of Environmental Services during record review from 9:25 a.m. to 12:00 p.m. on 06/03/14, third shift fire drills conducted on 05/22/13, 11/18/13 and 03/03/14 were each conducted at 12:00 a.m. Based on interview at the time of record review, the Director of Environmental Services acknowledged the aforementioned third shift fire drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p>				