STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 10/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

(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: 10/07/14 Facility Number: 000376 Provider Number: 155717 AIM Number: 100275510 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, the Alpha Home Association of Greater Indianapolis, Inc. 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. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke	K010000		

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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	detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 86 and had a census of 31 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one detached storage shed. Quality Review by Dennis Austill, Life Safety Code Specialist on 10/16/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
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 for the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hr duration.	K010046	**K 046 NFPA 101 Life Safety Code Standard Corrective Action Taken Related to this Finding: The Emergency generator contractor Buckeye has inspected the generator and made recommendations for the testing of the battery power emergency lighting to tested for the One and half hour duration. The monthly log form is completed by maintenance documented and**	11/06/2014

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	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 "Emergency Generator-Monthly Test Log" battery operated light testing documentation for the most recent twelve month period with the Administrator and the Maintenance Director from 10:00 a.m. to 11:20 a.m. and 1:40 p.m. to 3:00 p.m. on 10/07/14, documentation of an annual test for the battery powered emergency light located at the emergency generator for not less than 1 ½ -hr duration for the most recent twelve month period was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 10/07/14, one battery powered emergency light is located at the emergency generator location which failed to operate when the test button was pushed five times. Based on interview at the time of record review, the Administrator and the Maintenance Director acknowledged documentation of an annual test for not less than 1 ½ -hr		**stored in a three ring binder. The facility understands this is an annual test for the battery operated emergency testing. II.Other Residents with Potential to be affected by this finding will be identified by: Potentially all the residents can be affected by this finding, however at the time of this finding no additional residents were identified. The facility has begun the annual testing and replace the generator parts per the generator contractor specification. III.Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: The maintenance department will be responsible for the annual test with the battery power emergency lighting. The Supervisor will completed the log sheet establishing the designated month for the test to be completed. The log will be dated and placed in a three ring binder for viewing. IV.Corrective Actions will be monitored to Ensure Compliance by: The log sheets shall be be brought to the Quality Assurance meeting for review and recommendation by the Quality . Additional recommendations and improvements to facility maintenance directed by the**	

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	duration for the battery powered emergency light located at the emergency generator for the most recent twelve month period was not available for review. 3.1-19(b)		**administrator under the leadership of the committee.**	
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 activation of the fire alarm system for first and 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	K010050	**K 050 NFPA 101 Life Safety Code Standard Corrective Action Taken Related to this Finding: Circle City Fire Protection has submitted the annual testing for the alarm system inspection. This inspection sheet shall be kept in the quality assurance logbook as well as a copy the**	11/16/2014

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	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. Findings include: Based on review of "Fire Drill Report" documentation with the Administrator and the Maintenance Director during record review from 1:40 p.m. to 3:00 p.m. on 10/07/14, documentation for the first shift fire drill conducted on 08/20/14 at 2:00 p.m. stated "Announcement" as the response to "Fire Alarm Activation Method". In addition, "NA" was stated as the response to "Fire alarm system tested" and "Monitoring company received signal at." Documentation was left blank as the response to "Fire Alarm Activation Method", "Fire alarm system tested" and "Monitoring company received signal at" for the second shift fire drill conducted on 09/20/14 at 3:00 p.m. Based on interview at the time of record review, the Administrator stated no additional fire drill documentation was available for review and acknowledged the aforementioned fire drill documentation did not include		**maintenance supervisor. The contract calls for once a year testing of the fire alarm system. II.Other Residents with Potential to be affected by this finding will be identified by: Potentially all the residents can be affected by this finding, however at the time of this finding no additional residents were identified. III.Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: The fire alarm monitoring company will submit the log sheet when notified about the fire drill test. The fire drill sheet will have the signature and the notification specifically y of Once a month during the fire drill the alarm will be placed in test mold for the follow up with the drill. The monitoring company shall be notified with the start and completion of the drill. Follow up documentation shall be submitted by the monitoring that the system functioned properly during the drill test. Since the inspection all smoke detectors have test and passed inspection. IV.Corrective Actions will be monitored to Ensure Compliance by: By the Quality Assurance monthly review of the logs and contractor test information.**	

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	activation of the fire alarm system and transmission of the fire alarm signal. 3.1-19(b)		**11/16/14**	
K010052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 1. Based on record review and interview, the facility failed to document annual testing of the facility fire alarm system. NFPA 72, 7-3.2 refers to fire alarm component testing frequencies in Table 7-3.2 which requires an annual fire alarm system test. Section 7-5.2 requires a permanent record of all inspections, testing and maintenance shall be provided that includes information requested in Figure 7-5.2.2. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review with the Maintenance Director and the Administrator from 10:00 a.m. to 11:20 a.m. and 1:40 p.m. to 3:00 p.m. on 10/07/14, documentation of annual testing of the fire alarm system was not	K010052	**K 052 NFPA 101 Life Safety Code Standard Corrective Action Taken Related to this Finding:**Enclosed with the report is the five year inspection of the sprinkler and the invoice for the service provided.The test was completed on 09/19/2014. **Circle City Fire Protection has submitted the annual testing for the alarm system inspection. This inspection sheet shall be kept in the quality assurance log book as well as a copy the maintenance supervisor. The contract calls for scheduling of the sprinkler system within four years six months of the last 5 year inspection.. II.Other Residents with Potential to be affected by this finding will be identified by: Potentially all the residents can be affected by this finding, however at the time of this finding no**	11/16/2014

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	available for review. Based on interview at the time of record review, the Administrator and the Maintenance Director acknowledged documentation of a fire alarm system inspection within the last twelve months was not available for review. 3-1.19(b) 2. Based on record review, observation and interview; the facility failed to ensure 4 or more of at least 38 smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.		**additional residents were identified. III.Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows:**Computerized pre billed invoice within 4 years 6 months to accomondate the scheduling and completion of the 5 five year inspection of the sprinkler system. **IV.Corrective Actions will be monitored to Ensure Compliance by: Quality Assurance monthly review of the logs. Contractor pre authorize invoice befor the scheduled test. 11/16/14**	

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	To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of SafeCare's "Sensitivity Test & Inspection Report" documentation dated 11/12/13 with the Maintenance Director and the Administrator from 10:00 a.m. to 11:20 a.m. and 1:40 p.m. to 3:00 p.m. on 10/07/14, four of 38 smoke detectors were listed as failing smoke detector sensitivity testing within the most recent			

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	two year period. The four detectors failing sensitivity testing were located in Room 210. 211, 214 and 217. In addition, the aforementioned documentation stated 38 smoke detectors were tested but did not include smoke detector sensitivity testing for smoke detectors located in the 100 and 400 Hall. Based on observation with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 10/07/14, smoke detectors hard wired to the fire alarm system were installed in the 100, 200, 300 and 400 Hall and all 43 resident sleeping rooms. Based on interview at the time of record review, the Administrator stated repair or replacement documentation for the aforementioned four smoke detectors was not available for review and acknowledged documentation of smoke detector sensitivity testing in the last two years for all facility smoke detectors was not available for review. 3.1-19(b)			
K010062 SS=F	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 1. Based on record review, observation	K010062	**Addendum K 62Alpha Home Summary Requested**	11/16/2014

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	and interview; the facility failed to ensure quarterly sprinkler inspections were conducted for the sprinkler system for 1 of 4 calendar quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code to be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of Circle City Fire Protection "Report of Inspection" documentation dated 01/29/14, 05/30/14 and 08/27/14 with the Administrator and the Maintenance Director during record review from 10:00 a.m. to 11:20 a.m. and 1:40 p.m. to 3:00 p.m. on 10/07/14, the fourth quarter (October, November, December) 2013 sprinkler system inspection report was not available for review. Based on observation with the		**Addendum forOriginal POC November 16, 2014 1. K 062 Whatcorrective measures have been taken to ensure the automatic sprinkler systemwas examined internally for obstructions every 5 years?** 1 Enclosed please find the 5 year inspection reportsubmitted by the sprinkler company. This inspection report was completed on09/19/2014. Circle City Fire Protection has agreed to submit the preinvoiced 5 year inspection report within the 4 years and 6 months' time frame. **2. What measures andsystemic changes were put into place to assure deficient practice does notrecur?** There was meeting with the maintenance department and CircleCity Management to ensure the processing of the invoice and payment within 4years and 6 months prior to the five year inspection report. Maintenance Director and Administrator to have5year inspection within 4 years six months. Circle City Fire protection has agreed to provide theinspection. The Maintenance Director and Supervisor is responsible isresponsible for ensuring the 5 year sprinkler inspection is completed. # 2 what corrective action will be accomplished to ensurethe escutcheon plates are not missing? Each month prior to the fire drill, all sprinkler heads andescutcheon plates will be log	

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	Maintenance Director during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 10/07/14, calendar quarter sprinkler inspection tags affixed to the sprinkler system riser in the main mechanical room did not document a fourth quarter 2013 inspection. Based on interview at the time of record review and observation, the Administrator and the Maintenance Director acknowledged the fourth quarter 2013 sprinkler system inspection report was not available for review. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler systems was inspected every five years as required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 10-2.2 states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, staff and visitors in the facility.		for certainty that both are in place. 2. What measures andsystemic changes were put into place to assure deficient practice does notrecur? 1. Before monthly fire drills each sprinkler head andescutcheon plates are checked and logged. Safe care has agreed to provide the replacement escutcheonplates and sprinkler heads. The log sheets are presented to the Quality Assurance forreview and recommendation the facility will have a cabinet in the maintenanceroom with extra sprinkler heads and plates. **K 062 NFPA 101 Life Safety Code Standard Corrective Action Taken Related to this Finding: Is the policy of the Alpha Home to conduct quarterly sprinkler system reports for the sprinkler system, the sprinkler system test results for September 2014 has been placed in a three ring binder? Each quarterly sprinkler report saved and a copy placed with the quality assurance committee as well as maintenance. II.Other Residents with Potential to be affected by this finding will be identified by: Potentially all the residents can be affected by this finding, however at the time of this finding no additional residents were identified. 1.Quarterly calendar posted with maintenance and supplied by the sprinkler**	

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	Findings include: Based on review of Circle City Fire Protection "Report of Inspection" documentation dated 08/27/14 with the Administrator and the Maintenance Director during record review from 10:00 a.m. to 11:20 a.m. and 1:40 p.m. to 3:00 p.m. on 10/07/14, documentation of an internal pipe inspection for the facility's automatic sprinkler system within the most recent five year period was not available for review. The aforementioned report stated "05/15/09" as the response to "Owner's Section" item "D. When was the system piping last checked for stoppage, corrosion or foreign material?" Based on observation with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 10/07/14, 05/15/09 was written on the sprinkler system riser as the date of the most recent internal pipe inspection. Based on interview at 3:00 p.m. on 10/07/14, the Administrator stated sprinkler piping was replaced recently due to a water leak, documentation of the extent of sprinkler system piping replacement was not available for review and acknowledged he did not know if sprinkler system piping replacement qualified as an internal pipe inspection per NFPA 25.		**company that specify the month and date of the sprinkler company completes the quarterly testing. III.Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: The scheduled calendar specifying the actual dates the quarterly date the test will be completed. IV.Corrective Actions will be monitored to Ensure Compliance by: Monitoring by the administrator will the schedule calendar at the quality Assurance meeting. 11/16/14**	

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	3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 3 of over 100 sprinkler heads were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect 28 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 10/07/14, the automatic sprinkler located in the Cart Storage Room by Room 308, the storage room in the Housekeeping Manager's Office and the Accounting Office closet each had a missing escutcheon. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned automatic sprinklers each had a missing escutcheon. 3.1-19(b)			
K010066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and			

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	include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4			
	Based on observation and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container with a self closing lid at 1 of 1 outside areas where smoking was permitted. This deficient practice could affect two residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 10/07/14, the outdoor smoking area located outside the Day Room had in excess of 50 extinguished cigarette butts	K010066	**K 066 LifeSafety Code Standard CorrectiveAction Taken Related to this Finding: All residents are supervised with a staff person while ot on the patio. After each scheduled smoking times cigarettes will be discarded into a self closing metal device. II.Other Residents with Potential to be affected by this finding will beidentified by: Any resident assessed for smoking and authorized for smoking on the patio shall be supervised for placement of cigarettes in the metal enclosed container. III.Measures and Systemic Changes put into Place to**	11/16/2014

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	deposited in an open top ash tray mounted on top of a trash can. In addition, extinguished cigarette butts were observed deposited in the trash can along with combustible trash. Two smoking towers for cigarette butts were noted but not all cigarette butts were deposited into a metal container with a self closing cover device into which ashtrays can be emptied in this area where resident, staff and visitor smoking was taking place. Based on interview at the time of the observations, the Maintenance Director acknowledged extinguished cigarette butts were deposited in an open top ash tray mounted on top of a trash can and were also observed deposited in the trash can along with combustible trash. 3.1-19(b)		**Assure Deficit Practices do notrecur are as Follows: Monitoring of the residents with a staff person who supervises the resident. After each smoking sessions the cigarettes shall placed in the metal container IV.Corrective Actions will be monitored to Ensure Compliance by: The facility maintenance will monitor the container after the smoking sessions to ensure the cigarettes have been properly discarded.ishow the practice will be monitored and ensure compliance.**	
K010069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review, observation 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 inspection and servicing of the fire	K010069	**K 069NFPA 101** **LifeSafety Code Standard** **CorrectiveAction Taken Related to this Finding:** **Thewritten fire safety policy is posted in the kitchen which states the use of ABCtype fire extinguisher for the various types of fires.**	11/16/2014

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	extinguishing system at least every six months. This deficient practice could affect five staff and visitors in the kitchen. Findings include: Based on record review with the Maintenance Director and the Administrator from 10:00 a.m. to 11:20 a.m. and 1:40 p.m. to 3:00 p.m. on 10/07/14, documentation of semiannual hood extinguishing system inspections within the most recent twelve month period were not available for review. Based on observation with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 10/07/14, the hood in the kitchen above fuel fired cooking equipment is equipped with a fire extinguishing system. Based on interview at the time of record review, the Administrator acknowledged semiannual kitchen hood system inspections within the most recent twelve month period was not available for review. 3.1-19(b)		**Additionally,in the kitchen area with a fire in this area the hood suppression system isactivated prior to the use of an ABC type fire extinguisher or K class fireextinguisher. Semiannual inspection to conduct by the Allied,** **II.Other Residents with Potential to be affected by this finding will beidentified by:** **Potentiallyall the residents can be affected by this finding, however at the time of thisfinding no additional residents were identified.** **III.Measures and Systemic Changes put into Place to Assure Deficit Practices do notrecur are as Follows: Thecontractor to provide inspection and inspection to the facility every six monthsfor fire extinguishers, and suppression systems.** **IV.Corrective Actions will be monitored to Ensure Compliance by:** **Copyof the six month reports to be kept on file with he quality assurance committee.**	
K010144	NFPA 101			

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SS=C	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, 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 for the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hr duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator-Monthly Test Log" battery operated light testing documentation for the most recent twelve month period with the Administrator and the Maintenance Director from 10:00 a.m. to 11:20 a.m. and 1:40 p.m. to 3:00 p.m. on 10/07/14, documentation of an annual test for the battery powered emergency light located	K010144	**K144 NFPA 101 LifeSafety Code Standard CorrectiveAction Taken Related to this Finding: TheEmergency generator contractor Buckeye has inspected the generator and made recommendationsfor the testing of the battery power emergency lighting to test for the One andhalf hour duration. The monthly log form is completed by maintenance documentedand stored in a three ring binder. The facility understands this is an annualtest for the battery operated emergency testing. II.Other Residents with Potential to be affected by this finding will beidentified by: Potentiallyall the residents can be affected by this finding, however at the time of thisfinding no additional residents were identified. Thefacility has begun the annual testing and replace the generator parts per the generatecontractor specification. III.Measures and Systemic Changes put into Place to Assure Deficit Practices do notrecur are as Follows: Themaintenance department will be responsible**	11/06/2014

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	at the emergency generator for not less than 1 ½ -hr duration for the most recent twelve month period was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 11:20 a.m. to 1:40 p.m. on 10/07/14, one battery powered emergency light is located at the emergency generator location which failed to operate when the test button was pushed five times. Based on interview at the time of record review, the Administrator and the Maintenance Director acknowledged documentation of an annual test for not less than 1 ½ -hr duration for the battery powered emergency light located at the emergency generator for the most recent twelve month period was not available for review. 3.1-19(b)		**for the annual test with the batterypower emergency lighting. The Supervisor will complete the log sheetestablishing the designated month for the test to be completed. The log will bedated signed and placed in a three ring binder for viewing. IV.Corrective Actions will be monitored to Ensure Compliance by: Thelog sheets shall be brought to the Quality assurance meeting for review andrecommendation by the Quality Assurance committee. Additionalrecommendations and improvements to facility maintenance directed by theadministrator under the leadership of the committee. 11/6/14**	
K010154 SS=C	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			

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	service. 9.7.6.1 Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period in order to protect 31 of 31 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director and the Administrator from 10:00 a.m. to 11:20 a.m. and 1:40 p.m. to 3:00 p.m. on 10/07/14, a written fire watch policy in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period was not available for review. Based on interview at the time of record review, the Administrator acknowledged a written fire watch policy in the event the	K010154	**K154** **Life Safety Code Standard** **CorrectiveAction Taken Related to this Finding:** **Thewritten fire watch has been submitted along with the documented fire watch log. Thepolicy was also posted at the nurse's station for review by the surveyor.** **II.Other Residents with Potential to be affected by this finding will beidentified by: Potentiallyall the residents can be affected by this finding, however at the time of thisfinding no additional residents were identified.** **III.Measures and Systemic Changes put into Place to Assure Deficit Practices do notrecur are as follows: The copy of the watch is placed at the nurse station,administrator office dietary and the maintenance office. Firewatch policy placed in the plastic sleeve for review by surveyor.** **IV.Corrective Actions will be monitored to Ensure Compliance by: Policysupplied to the Quality Assurance committee.**	11/16/2014

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	automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period was not available for review. 3.1-19(b)		**LogsProvided to the Quality Assurance Committee.** **11/16/14**	
K010155 SS=C	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 Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 in order to protect 31 of 31 residents. This deficient practice could affect all residents, staff and visitors.	K010155	**K155** **Life Safety Code Standard** **CorrectiveAction Taken Related to this Finding:** **Thewritten fire watch has been submitted along with the documented fire watch log. Thepolicy was also posted at the nurse's station for review by the surveyor.**	11/16/2014

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	Findings include: Based on record review with the Maintenance Director and the Administrator from 10:00 a.m. to 11:20 a.m. and 1:40 p.m. to 3:00 p.m. on 10/07/14, a written fire watch policy in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period was not available for review. Based on interview at the time of record review, the Administrator acknowledged a written fire watch policy in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period was not available for review. 3.1-19(b)		**II.Other Residents with Potential to be affected by this finding will beidentified by: Potentiallyall the residents can be affected by this finding, however at the time of thisfinding no additional residents were identified.** **III.Measures and Systemic Changes put into Place to Assure Deficit Practices do notrecur are as follows: The copy of the watch is placed at the nurse station,administrator office dietary and the maintenance office. Firewatch policy placed in the plastic sleeve for review by surveyor.** **IV.Corrective Actions will be monitored to Ensure Compliance by: Policysupplied to the Quality Assurance committee. LogsProvided to the Quality Assurance Committee.** **11/16/14**	