

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410
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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: 12/18/13</p> <p>Facility Number: 000253 Provider Number: 155362 AIM Number: 100266660</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center - Merrillville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms</p>	K010000		
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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>are provided with battery powered smoked detectors. The facility has the capacity for 164 and had a census of 136 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/06/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010021 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 attic mechanical room smoke barrier doors was held open only by a device which would allow it to close upon activation of the fire alarm system. This deficient practice could affect visitors and 2 or more staff in the attic mechanical room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/18/13 at 4:10 p.m., the smoke barrier door separating the unoccupied attic mechanical room from the adjacent attic space above the facility service areas was held wide open by a length of pipe positioned to prevent the door from closing. The maintenance director</p>	K010021	<p>K21No residents would be affected by this deficient practice.Immediate intervention was the removal of the pipe holding the door.Maintenance Staff, Air Temp, Mechanical Concepts, Continental Electric and Safe Care will be in-serviced regarding not blocking any attic mechanical room smoke barrier door.A line item will be added to the weekly smoke door checks (see attached) to ensure that all attic smoke doors are not blocked.Date of Completion: January 24, 2014</p>	01/24/2014
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K010025 SS=E	<p>acknowledged at the time of observation, the door should not have been prevented from closing.</p> <p>3.1-19(b)</p> <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 3 of 3 openings in ceiling smoke barriers were sealed to maintain the smoke resistance of the smoke barriers. 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</p>	K010025	<p>K25This deficient practice could potentially affect at least 20 residents.Immediately the 3 openings are sealed to secure the smoke barrier.There will be weekly rounding for identification of any new penetrations this will be done along with the sprinkler gauge checks; a line item will be added to the existing form (see attached). As well the ACE rounding will have a focus to watch for penetrations during their rounding. Date of completion: January 24, 2014</p>	01/24/2014

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	<p>approved device designed for the specific purpose. This deficient practice could affect at least 20 or more residents, visitors, and staff in the dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/18/13 between 12:30 p.m. and 3:00 p.m., ceiling smoke barrier penetrations were unsealed:</p> <p>a. In the laundry/housekeeping supply storage room where a four inch hole was open to the attic;</p> <p>b. In the laundry where a water pipe and 10 inch duct left annular gaps of one inch into the attic above;</p> <p>c. In the laundry where a two inch hole was not firestopped and the maintenance director said at the time of observation, a sprinkler head was moved. The maintenance director acknowledged the openings should have been sealed.</p> <p>3.1-19(b)</p>						

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K010029 SS=E	<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 a door serving a hazardous area such as a room larger than 50 square feet storing combustible materials closed and latched to prevent the passage of smoke. This deficient practice could affect visitors, staff and 10 or more residents on D wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/18/13 at 1:55 p.m., room 328, a former D wing resident room which exceeded 50 square feet, had 10 or more wheelchairs, vinyl clad pads, cushions and other equipment in storage. The door had no means to self close. The maintenance director said at the time of observation, he was did not know the door should self close.</p>	K010029	K29This deficient practice could potentially affect 10 or more residents.The Maintenance Director will install a self-closer on the wheel chair room door.This will be a permanent fix for this citingTo monitor this process there has been a line item added to the weekly Fire Door check (see attached).Date of Completion: January 24. 2014	01/24/2014	

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K010038 SS=E	<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 6 of 13 exterior exit discharges were arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect residents, staff and 20 or more residents in the main dining room and the ACU, C, and D wings.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 12/18/13 between 12:30 p.m. and 4:00 p.m., emergency exit discharges were covered with areas of ice and snow for the exits from the A, B and C halls on D wing, the C hall on C wing, and the C hall on the ACU. The maintenance director</p>	K010038	K38This deficient practice could potentially affect 20 or more residents. A. Floor staff and Unit Managers will be in-serviced regarding the monitoring of emergency exits during inclement weather to ensure pathways are clear of hazardous conditions. During Maintenance Rounding they will be checking the emergency pathways and monitoring this on the daily PM work sheet (see attached).We have a contract service with Don's Snow Removal which also helps to monitor the emergency pathways (per the contract they will be present and when there is one inch of snow or greater, see attached). B. Maintenance will fill and level the 2 inch variance in the southeast concrete exit discharge surface.The potential of future surface variances will be monitored through weekly PM facility rounding.Date of Completion: January 24, 2014	01/24/2014			

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K010046 SS=F	<p>acknowledged at the time of observations the surfaces should have been cleared.</p> <p>b. Based on observation with the maintenance director on 12/18/13 at 2:25 p.m., the southeast concrete exit discharge surface for the main dining room was cracked across the width of the surface and had a two inch change in the surface level at the meeting edges between an expansion joint and the damaged surface. The maintenance director acknowledged at the time of observation, the discharge surface was not level.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1. Based on record review and interview, the facility failed to provide documentation of 30 second periodic testing at 30 day intervals and annual testing for 1 1/2 hours for 25 of 25 battery powered emergency lighting fixtures. LSC 7.9.3 requires a functional</p>	K010046	K46This deficient practice could potentially affect all residents.Immediate intervention was performing a facility wide sweep to ensure proper function of Emergency Lighting.A form has been developed to ensure the monitoring of the emergency lighting and the location of each	01/24/2014

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	<p>test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test shall be conducted for not less than 1 1/2 hours. Written records of visual inspections and tests shall be kept. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of facility fire safety inspection and test records with the maintenance director on 12/18/13 at 3:30 p.m., a Preventative Maintenance report for Emergency Lighting, Battery Operated for battery powered emergency lighting fixtures located throughout the facility noted the steps required for testing the fixtures. The maintenance director said at the time of record review, a check mark meant the testing had been done on all fixtures, however, a list of the specific fixtures tested, their location, and the test results was not part of the record. The maintenance director acknowledged the record provided did not actually document the actual monthly and annual test performance for these light fixtures.</p> <p>3.1-19(b)</p>		Emergency Lighting and Battery Operated Emergency Lighting (see attached). There will be testing done each month to ensure each emergency lighting is properly functioning. This monitoring will be done along with the standard 30 second function test. Date of Completion: January 24, 2014				

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K010050 SS=F	<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. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 4 of the last 4 quarters. This deficient practice could affect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's Quarterly Fire Drill records and interview with the maintenance director on 12/18/13 at 3:55 p.m., there was no</p>	K010050	<p>K50This deficient practice has the potential to affect all residents.Intervention for correction is adding a line item to the Safety Committee Agenda and Minutes(see attached); to present quarterly during Safety Committee meetings. This form will be presented with the dates and times of all fire drills done that quarter.Date of Completion: January 24, 2014</p>	01/24/2014

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K010054 SS=F	<p>record of a first shift fire drill during the first quarter of 2013 or the third shift during the fourth quarter of 2012. The maintenance supervisor acknowledged at the time of record review, fire drill records were incomplete.</p> <p>3.1-9(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 Based on record review and interview, the facility failed to ensure 81 of 81 smoke detectors had been sensitivity tested. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 says a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with NFPA 72, National Fire Alarm Code. NFPA 72 at 7-3.2.1 states, "Detector</p>	K010054	K54Please see attached 2012 sensitivity test with all repairs done; as evidence that compliance was met.	01/24/2014	

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	<p>sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <ol style="list-style-type: none"> (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 acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. <p>Detectors found to have sensitivity outside the listed and marked sensitivity</p>			

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	<p>range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector." This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on a review of the fire system inspection and testing records with the maintenance director on 12/18/13 at 3:50 p.m., a sensitivity test record was not found. The maintenance director offered a Report of Inspection dated 07/09/13 as a current sensitivity test report, but the documentation indicated only function testing was done. The maintenance director said at the time of record review, he could not find the sensitivity testing record.</p> <p>3.1-19(b)</p>				

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K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure cylinders of nonflammable gases in 1 of 1 D Wing oxygen supply storage rooms were properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect visitors, staff and 10 or more residents on D wing.</p> <p>Findings include:</p>	K010076	K76 This deficient practice could potentially affect 10 or more residents. The 2 oxygen cylinders cited have been chained to the wall for security. A line item has been added to the Oxygen Room Audit form (see attached) as a monitoring system to routinely check that all e-cylinders are secured to wall. Date of completion: January 24, 2014	01/24/2014

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K010147 SS=E	<p>Based on observation with the maintenance director on 12/18/13 at 1:40 p.m., two oxygen e-cylinders were stored without support in the D wing oxygen supply storage room with six liquid oxygen containers. The maintenance director said at the time of observation, the cylinders should have been secured by the chain available for that purpose.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure 7 of 7 electrical wiring connections were maintained in a safe operating condition which included junction boxes. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect visitors, and 6 or more staff in the kitchen attic and mechanical room.</p>	K010147	<p>K147This deficient practice could potentially affect 6 or more residents.A. Immediately all junction boxes will have covers attached and will be monitored during the monthly maintenance rounding. This rounding will be monitored through the Electrical Maintenance form (see attached). B. Maintenance Dept will install an outlet for the attic condensation pump.C. In-service will be done facility wide to educate staff regarding the appropriate use of power strips</p>	01/24/2014			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410		
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	<p>Findings include:</p> <p>Based on observation with the maintenance director on 12/18/13 between 3:45 p.m. and 4:10 p.m., a junction box in the walk in kitchen freezer was left uncovered with wires covered with wire nuts exposed and six junction boxes in the attic mechanical room were left uncovered with wires covered with wire nuts exposed. The maintenance director acknowledged at the time of observations, the junction boxes should have been properly closed to protect the wiring.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure extension cords, including powerstrips, were not used as a substitute for fixed wiring in 2 of 14 smoke compartments. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect residents staff and 10 or more residents on the C and D wings.</p>		and there are to be no extension cords in the facility.Date of Completion: January 24, 2014		

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	<p>Findings include:</p> <p>Based on observation with the maintenance director on 12/18/13 between 1:00 p.m. and 2:30 p.m.:</p> <p>a. An extension cord ran from the attic condensate pump through the activity room ceiling and plugged into an electrical outlet in the room. The maintenance director said at the time of observation, there was no outlet for the pump in the attic above the room.</p> <p>b. A microwave and refrigerator were plugged into a power strip in the social services office;</p> <p>c. A power strip was located under the head of the resident bed in room 327 on D wing to power the equipment in the room. The maintenance director acknowledged at the time of observations, these power sources were not appropriate.</p> <p>3.1-19(b)</p>			
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K010154 SS=F	<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 observation and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 136 of 136 residents in the event the automatic sprinkler system has to be placed out of service for four hours within 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</p>	K010154	K154This deficient practice could potentially affect all residents.Please see attached Fire Watch documentation for the completion of the written policy regarding fire watch procedure for the sprinkler system. Date of Completion: January 20, 2014	01/24/2014

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	<p>building fire alarm system. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's documentation provided for a fire watch procedure to follow in the event the automatic sprinkler system was out of service with the maintenance director on 12/18/13 at 3:40 p.m., the documentation was incomplete. The documentation did not include all elements required for implementation of a fire watch if the automatic sprinkler system is out of service for four hours in a twenty four hour period; notice to the fire department and ISDH, and the documentation of the fire watch tour every fifteen minutes. The maintenance director acknowledged at the time of record review, the fire watch procedure was incomplete.</p> <p>3.1-19(b)</p>				

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K010155 SS=F	<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 observation and interview the facility failed to provide a complete written policy containing procedures to be followed to protect 136 of 136 residents in the event the fire alarm system has to be placed out of service for four hours within a 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's documentation provided as evidence of the policy and procedures to follow in the event the fire alarm system was out of service with the administrator and maintenance director on 12/18/13 at 3:40 p.m., the documentation was incomplete. The procedure did not include all elements required such as the implementation of a fire watch if the fire alarm system is out of service for four hours in a twenty four hour period, and notifying the fire department and Indiana</p>	K010155	K155This deficient practice has the potential to affect all residents.Please see attached Fire Watch documentation for the completion of the written policy regarding fire watch procedure for the fire alarm system.Date of Completion: January 20, 2014	01/24/2014			

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	State Department of Health. The maintenance director acknowledged at the time of record review, a policy including all required elements for implementing a fire watch requirement was not provided. 3.1-19(b)				