STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155324	A. BUILDING -- B. WING	12/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	. An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/11/17 Facility Number: 000217 Provider Number: 155324 AIM Number: 100289590 At this Emergency Preparedness survey, Mitchell Manor was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 171 certified beds. At the time of the survey, the census was 60. Quality Review completed on 12/19/17 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0004 SS=C				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Bldg. --	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Disaster Plan on 12/11/17 between 2:30 p.m. to 4:00 p.m. with the Plant Operations Manager present, documentation for a complete emergency program reviewed by the facility within the most recent twelve month period was not available for review. Most of the disaster plan available had most recent review dates of 2004 and 2008. Based on interview at the time of record review, the Plant Operations Manager indicated the facility has not had its entire emergency preparedness program reviewed by the facility within the most recent twelve month period and agreed the aforementioned plan does not address policies and procedures based on a facility and community based risk assessment and communication plan utilizing an all-hazards approach to assist the facility in addressing the needs of their resident populations, along with identifying the continuity of business	E 0004	E OO4 The disaster plan which has been reviewed many times had a date on the bottom of the page stating the last time it was ADDED to or ALTERED. It is the policy of this facility to maintain the safety of our residents in accordance with 42CFR Subpart 483.73 I provide documentation of working with another facility and our local school system as well. 2. We have taken steps immediately to go through the book, and to put the documentation closer to the front of the emergency plan manuals. 3. To ensure the alleged deficient practices do not recur, the Maintenance Director or designee will arrange 2 separate annual meetings with 2 different commitees. first the safety committee and place signatures sheet in the manual and than the department heads of our facility and will leave their signatures as well.	01/10/2018

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	operations and the facility's ability to collaborate with local emergency preparedness officials was not available for review.			
E 0009 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the LTC facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in accordance with 42 CFR 483.73(a)(4). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Disaster Plan on 12/11/17 between 2:30 p.m. to 4:00 p.m. with the Plant Operations Manager present, documentation for a complete emergency program reviewed by the facility within the most recent twelve	E 0009	E 009 The documentation was provided for contact with our local school system and also another local facility, it has been moved closer to the front of the manual and will be addressed at our meeting annually and recontacted to ensure understanding and good communication. The local police and fire dept will be contacted as well per CFR 483.73 a 4 . 2. Our documents were reviewed by a small committee to ensure 100% we had made contacts with local officials and documents were in place. 3. We are not a dialyses facility, as typed in E 009 but as a system to make sure this allegation doesn't recur we will have meeting each year with 2 separate committees to ensure that the proper officials are contacted and it will be documented and signed signatures with the manual. 4. The Maintenance Director or a designee will ensure these meetings occur and the contacts	01/10/2018

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	month period was not available for review. Most of the disaster plan available had most recent review dates of 2004 and 2008. Based on interview at the time of record review, the Plant Operations Manager indicated the facility has not had its entire emergency preparedness program reviewed by the facility within the most recent twelve month period and agreed the aforementioned plan of the facility's ability to collaborate with local emergency preparedness officials was not available for review.		are made as has been done.	
E 0013 SS=C Bldg. --	Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's Disaster Plan on 12/11/17 between 2:30 p.m. to 4:00 p.m. with the Plant Operations Manager present, documentation for a complete emergency program reviewed by	E 0013	1.There was another review of the plan, and documentation was moved closer to the front . The revision dates listed at the bottom of the pages were left the same as when they were last revised. It did not mean they had not been reviewed since 2004 or 2008. They say revised , not reviewed, and documentation was shown from a previous year. 2.We will be making more reviews and changes to the emergency plan to make it easier to follow and understand and will work on removing the revised dating so as not to be misunderstood. 3.Maintenance Director or a designee appointed will ensure 2 meetings a year occur and	01/10/2018

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	the facility within the most recent twelve month period was not available for review. Most of the disaster plan available had most recent review dates of 2004 and 2008. Policies and procedures based on a facility and community based risk assessment and communication plan utilizing an all-hazards approach was not available for review. Based on interview at the time of record review, the Plant Operations Manager indicated the facility has not had its emergency preparedness program reviewed by the facility within the most recent twelve month period and the aforementioned plan does not address policies and procedures based on a facility and community based risk assessment and communication plan utilizing an all-hazards approach.		contacts made and signature sheet be left in the emergency plan manual. 4.Maintenance Director or designee will report to the Safety Committee to show proof this is being done this coming full year.	
E 0029 SS=C Bldg. --	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all residents in the facility.	E 0029	1.There was another review of the plan, and documentation was moved closer to the front . The revision dates listed at the bottom of the pages were left the same as when they were last revised. It did not mean they had not been reviewed since 2004 or 2008. They say revised , not reviewed, and documentation was shown from a previous year. 2.We will be making more reviews	01/10/2018

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	Findings include: Based on review of the facility's Disaster Plan on 12/11/17 between 2:30 p.m. to 4:00 p.m. with the Plant Operations Manager present, documentation for a complete emergency program reviewed by the facility within the most recent twelve month period was not available for review. Most of the disaster plan available had most recent review dates of 2004 and 2008. Based on interview at the time of record review, the Plant Operations Manager indicated the facility has not had its emergency preparedness program reviewed by the facility within the most recent twelve month period and the plan does not include a communication plan that contains how the facility coordinates resident care within the facility, across health care providers, and coordination with state and local public health departments.		and changes to the emergency plan to make it easier to follow and understand and will work on removing the revised dating so as not to be misunderstood. 3.Maintenance Director or a designee appointed will ensure 2 meetings a year occur and contacts made and signature sheet be left in the emergency plan manual. 4.Maintenance Director or designee will report to the Safety Committee to show proof this is being done this coming full year.	
E 0036 SS=C Bldg. --	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR	E 0036	1.There was another review of the plan, and documentation was moved closer to the front . The revision dates listed at the bottom of the pages were left the same as when they were last revised. It did not mean they had not been	01/10/2018

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	483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Disaster Plan on 12/11/17 between 2:30 p.m. to 4:00 p.m. with the Plant Operations Manager present, documentation for a complete emergency program reviewed by the facility within the most recent twelve month period was not available for review. Most of the disaster plan available had most recent review dates of 2004 and 2008. Based on interview at the time of record review, the Plant Operations Manager indicated the facility has not had its emergency preparedness program reviewed by the facility within the most recent twelve month period and the plan does not include an emergency preparedness training and testing program that was reviewed and updated during the past twelve month period.		reviewed since 2004 or 2008. They say revised , not reviewed, and documentation was shown from a previous year. 2.We will be making more reviews and changes to the emergency plan to make it easier to follow and understand and will work on removing the revised dating so as not to be misunderstood. 3.Maintenance Director or a designee appointed will ensure 2 meetings a year occur and contacts made and signature sheet be left in the emergency plan manual. 4.Maintenance Director or designee will report to the Safety Committee to show proof this is being done this coming full year.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a).	K 0000		

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	Survey Date: 12/11/17 Facility Number: 000217 Provider Number: 155324 AIM Number: 100289590 At this Life Safety Code survey, Mitchell Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery powered smoke alarms in all resident sleeping rooms. The facility has a capacity of 171 and had a census of 60 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except a garage and two storage barns used for facility storage.			

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	Quality Review completed on 12/19/17 - DA			
K 0321 SS=B Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220) Based on observation and interview, the	K 0321	K 321	01/10/2018

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	facility failed to ensure corridor doors to 2 of over 15 hazardous area room doors were provided with self closing devices. This deficient practice could affect any residents, as well as staff and visitors while in the Williams Wing, which currently has no occupied resident rooms but the Physical Therapy is located at the east end of the corridor. Findings include: Based on observation on 10/19/17 at 1:30 p.m. during a tour of the facility with the Administrator-in-Training (AIT), the corridor door to the storage room in the old house section, where at least 10 cardboard boxes, wheelchairs, old beds, and other items were stored, was not provided with a self closing device. Based on interview at the time of observation, the AIT agreed the door to the storage room lacked a self closing device. 3.1-19(b)		It is the policy of this facility to keep closures on storage doors in accordance to the code . 1.The door closures that had not been on 2 rooms in the corridor the therapy end have been reinstalled. 2. All storage areas that meet this minimum in storage have been checked to ensure they have door closures and are checked weekly. 3.Systems to ensure alleged deficient practice does not recur: Maintenance Director or designee will continue monitoring the doors during the weekly check 4.Monitoring to ensure alleged practice does not recur, the Maintenance Director or Designee will present weekly checks to the QI for 4 consecutive months.	
K 0331 SS=B Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of			

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	Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation and interview, the facility failed to ensure 1 of 10 smoke compartments was provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility. LSC 3.3.90.4 defines interior wall finish as the interior finish of columns, fixed or movable walls, and fixed or movable partitions. A.3.3.90.2 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient practice could affect mostly staff in the laundry room, plus any residents while in the same smoke compartment. Findings include: Based on observation on 12/11/17 at 1:39 p.m. during a tour of the facility with the Plant Operations Manager, there was a two foot by four foot section of the wall with exposed wood studs on the interior of the dryer room within the laundry room. This was acknowledged by the Plant Operations Manager at the time of observation, furthermore, the Plant Operations Manager	K 0331	K 331 It is the policy of this facility to keep the code for covering of interior walls for fire and smoke protection. 1. The solid 2x4 boards that were being used as smoke and fire barriers to ensure no smoke or fire traveled between the partitioned wall near dryers has been dry walled and coated with wall finish over this partition. 2. This portion of the building has been 100% assessed and is sealed properly. 3. Systems to ensure alleged deficient practice does not recur: Maintenance Director or Designee will continue monitoring storage areas and laundry area to ensure proper coverage. 4. Monitoring to ensure this alleged deficient practice does not recur, the Maintenance Director or designee will present weekly checks to the QI committee for 4 consecutive months.	01/10/2018

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	said the exposed wood studs did not have a flame spread rating. 3.1-19(b)			
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written policy for the protection of 60 of 60 residents indicating 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 twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants in the facility. Findings include: Based on record review on 12/11/17 at 12:30 p.m. with the Plant Operations Manager present, the facility provided fire watch documentation, however, it was incomplete. The plan failed to include the	K 0346	The policy of this facility is to contact the fire department and the maintenance director and ED if the sprinkler system or alarm system fails. These people will contact the state and insurance company. Those numbers which are all in the manual. Including the Insurance company and the state contact phone number. The Gateway portal web link was added to the manual. 1.The policy for fire watch was located in the manual and another copy was made and moved to the front of book to save confusion in the future. 2.The policy does have the numbers listed and explains the process well. 3.Systems to ensure alleged deficient practice does not recur:	01/10/2018

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	web link for contacting the Incident Reporting System located on the Indiana State Department of Health Gateway, plus the phone number for the local fire department, and contacting the facility's insurance carrier with phone number. Based on an interview at the time of record review, the Plant Operations Manager agreed the fire watch policy lacked the previously mentioned information. 3.1-19(b)		Maintenance Director or designee will check annually to ensure the policy is in 2 locations in the book for easier access. 4.Monitoring to ensure alleged deficient practice does not recur: Maintenance Director or designee will annually have 2 committees check the manual during review to ensure information is at hand and readily accessible	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 5 of over 500	K 0353	K 353 It is the policy of this facility to ensure that the sprinkler system	01/10/2018

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	sprinkler heads in the facility were free of corrosion. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at 5.2.1.1.1 requires sprinklers to be free of paint and corrosion. 5.2.1.1.2 requires any sprinkler that shows signs of paint or corrosion shall be replaced. This deficient practice could affect mostly laundry and kitchen staff. Findings include: Based on observations on 12/11/17 between 12:30 p.m. and 2:30 p.m. during a tour of the facility with the Plant Operations Manager, the following was noted: a. 4 sprinkler heads in the laundry room was covered with corrosion b. 1 sprinkler head in the kitchen over the three compartment sink was covered with corrosion Based on interview at the time of observations, the Plant Operations Manager agreed the previously mentioned sprinkler heads were covered with corrosion. 3.1-19(b)		is correctly monitored and has correct inspection and maintenance. 1.Safecare has been contacted to bring new sprinkler heads to install in place of the discolored sprinkler heads in the kitchen and laundry and to do another inspection of them all as the Maintenance team has, to ensure any and all that don't meet our specifications are replaced. 2.The facility sprinkler heads have been checked for any further alleged deficiencies and will be checked again by Safecare ,an outside sprinkler inspection company. 3.Systems to ensure alleged deficiencies do not recur: Maintenance Director or designee will check the sprinkler heads throughout the building for discoloration every 3 months and will ensure SAFECAREdoes as well. There will be a log of every room in the facilty checked every 3 months. 4. Monitoring to ensure alleged deficient practice does not recur: Maintenance Director or designee will present quarterly inspection results to QI committee for a year.	
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the			

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	155324	A. BUILDING 01 B. WING	12/11/2017

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	extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed for the protection of 60 of 60 residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 12/11/17 at 12:30 p.m. with the Plant Operations	K 0354	The policy of this facility is to contact the fire department and the maintenance director and ED if the sprinkler system or alarm system fails. These people will contact the state and insurance company. Those numbers which are all in the manual. Including the Insurance company and the state contact phone number. The Gateway portal web link was added to the manual. 1.The policy for fire watch was located in the manual and another copy was made and moved to the front of book to save confusion in the future. 2.The policy does have the numbers listed and explains the process well. 3.Systems to ensure alleged deficient practice does not recur: Maintenance Director or designee will check annually to ensure the policy is in 2 locations in the book for easier access.	01/10/2018

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	Manager present, the facility provided fire watch documentation, however, it was incomplete. The plan failed to include the web link for contacting the Incident Reporting System located on the Indiana State Department of Health Gateway, plus the phone number for the local fire department, contacting the facility's insurance carrier with phone number. Based on an interview at the time of record review, the Plant Operations Manager agreed the fire watch policy lacked the previously mentioned information. 3.1-19(b)		4.Monitoring to ensure alleged deficient practice does not recur: Maintenance Director or designee will annually have 2 committees check the manual during review to ensure information is at hand and readily accessible	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 4 areas open to the corridor was separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping	K 0361	K 361 It is the policy of this facility to ensure that the building is adequately protected and monitored for fire and smoke hazards by a fully functional and maintained fire alarm and sprinkler system . 1.Safecare our contracted alarm and sprinkler company has been	01/10/2018

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	rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect any residents, as well as staff and visitors while in the Williams Wing, which currently has no occupied resident rooms but the Physical Therapy is located at the east end of the corridor. Findings include: Based on observation on 12/11/17 at 1:06 p.m. during a tour of the facility with the Plant Operations Manager, the Williams Wing old nurses' station was open to the corridor. The Williams Wing nurses' station is currently not being used. Furthermore, LSC 19.3.6.1(7) was not met because the Williams Wing nurses' station was not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of observation, the Plant Operations Manager said he did not realize there was not an electrically		contacted to come install a new smoke alarm on Williams wing . They will have it installed by the 10 of January. 2.100% of the facility is checked to ensure coverage by the smoke detectors. 3.Systems to ensure alleged deficient practice does not recur: Maintenance Director or designee will check smoke detectors on weekly inspection of corridors. 4.Monitoring to ensure alleged deficient practice does not recur will involve Maintenance Director or designee having Safecare checking quarterly to ensure we are still under proper coverage	

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	supervised automatic smoke detector in the Williams Wing nurses' station. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.			

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	19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 2 of 84 resident room corridor doors had no impediment to closing. This deficient practice could affect up to 21 residents, staff and visitors in the A wing. Findings include: Based on observations on 12/11/17 between 12:30 p.m. and 2:30 p.m. during a tour of the facility with the Plant Operations Manager, resident room corridor doors 116 and 112 were both held wide open with rubber door wedges. Based on interview at the time of observations, the Plant Operations Manager said he was not aware the door wedges were being used. 3.1-19(b)	K 0363	K 363 It is the policy of our facility to ensure that the doors are sufficient and adequate to protect anyone in our building to the extent of their design. 1.The rubber door wedges were removed and the staff was educated to the requirements of the unimpeded free clearance of the doors in case of an emergency. 2.The entire facility has been checked to ensure there is no more usage of any door stoppers. 3.Systems to ensure alleged deficient practice does not recur: Maintenance Director or designee will weekly check each door in the weekly hallway inspection and will document this is done in the Tels weekly program 4. Monitoring to ensure alleged deficient practice does not recur: Maintenance Director or designee will weekly document in Tels and present inspection results to QI committee for 4 consecutive months.	01/10/2018
K 0711 SS=C	NFPA 101 Evacuation and Relocation Plan			

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Bldg. 01	Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of 60 of 60 residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire	K 0711	K 711 It is marked in our Emergency Management Plan that the nurses and CNA' s and all staff are to remove all equipment from the hall to an unoccupied room. It is the facility policy that all equipment is to be removed from hallway during an emergency. 1.This policy has been checked throughout the Emergency Plan and found in multiple places. 2.The policy checked and updated by Russell Phillips each year clearly addresses this . 3.Systems to ensure alleged deficient practice will not occur: Maintenance Director or designee will check the emergency management plan yearly and have Russell Phillips an outside company review our policy. 4.Monitoring to ensure alleged deficient practice does not occur: Maintenance Director or designee	01/10/2018

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	Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the Fire Procedures on 12/11/17 at 3:30 p.m. with the Plant Operations Manager present, the fire safety plan did not address the issue of the relocation of wheeled equipment during a fire or similar emergency. Based on interview at the time of record review, the Plant Operations Manager agreed that the fire plan did not address the relocation of wheeled equipment during a fire or similar emergency. 3.1-19(b)		will present the Emergency Management Plan for review each year to 2 committees.	

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K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure 12 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 12/11/17 at 10:15 a.m. with the Plant Operations Manager present, all	K 0712	K 712 It is the policy of our facility to ensure fire drills are done monthly and properly documented. 1.The time of the call to verify the signal has been written on the latest fire drill beside the monitors name. The time of the signal and the call is always within the time written on the documentation of the start and end of the fire drill as was told by the Maintenance Director during the interview. 2.All fire drill documentation will have this time written on it. 3.System to ensure alleged deficient practice does not recur: Maintenance Director or designee has asked TELS SYSTEM to change the fire drill documentation to include a line specifically for this time of the signal going	01/10/2018

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	documented fire drills had the question "Person Contacted to Verify Signal" with the answer always someone's name at the monitoring company, however, all fire drill reports did not include the time the alarm transmission was received. Based on interview at the time of record review, the Plant Operations Manager agreed there was no documentation on the fire drill reports that included the time the monitoring company received the transmission of the alarm. 3-1.19(b)		through. 4.Monitoring to ensure alleged deficient practice does not recur: Maintenance Director or designee will show the ED/or Designee the changes to the fire drill document.	