STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155740	A. BUILDING 01 B. WING	11/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREST CHURCH OF THE BRETHREN HOME	2201 EAST ST NORTH MANCHESTER, IN 46962

(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
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). Survey Date: 11/07/17 Facility Number: 000448 Provider Number: 155740 AIM Number: 100275140 At this Life Safety Code survey, Timbercrest Church of Brethren Home 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 with a basement 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 areas open to the corridor. Battery operated smoke detectors were	K 0000	It is, and always has been the intent of Timbercrest that our building and practices are compliant with the Life Safety Code. Timbercrest requests desk review/ paper compliance for plan of correction submitted for life safety code survey exiting on 11/7/2017.	

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

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	installed in the resident rooms on the 100, 200, 300 and 400 halls. The facility has a capacity of 65 and had a census of 59 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached maintenance garage. Quality Review completed on 11/09/17 - DA			
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: * They are not intended to serve four or more inpatients. * They are separated from areas of health care occupancies by construction having a minimum 2-hour fire resistance rating in accordance with Chapter 8. * The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 1. Based on observation and interview, the facility failed to maintain the two-hour rated construction of 1 of 2	K 0131	1.It is, and always has been the intent of Timbercrest that all areas of health care occupancy	12/07/2017

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	separation walls between two different occupancies. LSC 8.3.5.1 states Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through- Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m2) between the exposed and the unexposed surface of the test assembly. 8.3.5.2 states where the penetrating item uses a sleeve to penetrate the wall or floor, the sleeve shall be securely set in the wall or floor, and the space between the item and the sleeve shall be filled with a material that complies with 8.3.5.1. This deficient practice could affect 25 residents in the health care facility. Findings include: Based on observation during a tour of the		are separated and maintained to ensure 2 hours of fire resistance. Timbercrest issued a work order for astragal to be placed and holes to be patched. 2.All other fire barriers were inspected during the Life Safety Survey process, no other areas of concern were identified. 3.Checking smoke barriers was added to monthly inspection of all fire barriers as a preventive maintenance tasks. 4.The Director of Maintenance or designee will review preventative maintenance work orders for completeness and concerns will be brought to the attention of the Associate Director and Timbercrest's QAPI, during QAPI-safety meeting. Preventative maintenance task for checking laundry chutes shall be ongoing for a period of no less than 3 years. 5.Compliance Date: 12/7/2017. Timbercrest requests desk review/ paper compliance for plan of correction submitted for K 131.	

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	facility with Lead Maintenance Technician on 11/07/17 at 1:03 p.m., the two hour fire wall that separated assisted living from health care contained the following unsealed two inch sleeve containing wires. Base on interview at the time of observation, the Lead Maintenance Technician provided the measurements of the unsealed sleeve. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 fire door sets were arranged to minimize the spread of fire and restrict the movement of smoke. LSC, 8.3.4.1 every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. This deficient was not in a resident care area but could affect any staff in the main basement. Findings include: Based on observation during a tour of the facility with the Maintenance Director, on 11/07/17 at 11:11 a.m., the fire door set in the basement that separated health care from assisted living had at least a 3/8th inch gap along the center where the doors came together in the closed position. This condition does not restrict			

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	the spread of fire and restrict the movement of smoke. Based on interview at the time of observation, the Maintenance Director confirmed the doors were occupancy separation fire doors and provided the measurement of the gap. 3.1-19(b)			
K 0353 SS=C 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 record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system gauges and valves had been inspected for 12 of 12 past months. LSC 4.6.12.1 requires any device,	K 0353	1.It is, and always has been the intent of Timbercrest that our facility's supervised automatic sprinkler system is maintained and tested. Immediate corrective action was sprinkler system's gauges and values were inspected and documented.	12/07/2017

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	equipment or system required for compliance with this code 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, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal supply pressure is being maintained. Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. NFPA 25, 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. This deficient practice could affect all residents, staff, and visitors in the facility.		2.All other sprinklers were inspected during the Life Safety Survey process, no other areas of concern were identified. 3.A clip board with inspection elements and documentation sheet was placed at location of inspection, to ensure documentation is maintained at the site to show monthly inspections. 4.The Director of Maintenance or designee will audit inspections. Audits will be conducted monthly for 3 months, until a compliance rate of 95% is obtained, and then quarterly, thereafter for a 12 month period. If any audit should be reveal a compliance rate of less than 95%, auditing will return to a monthly basis until 95% is obtained. Audit results will be reported through Timbercrest's QAPI process during QAPI-safety. 5.Compliance Date: 12/7/2017. Timbercrest requests desk review/ paper compliance for plan of correction submitted for K 353.	

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	Findings include: Based on record review with the Maintenance Director on 11/07/17 at 10:33 a.m., there was no monthly inspection of the wet sprinkler system's gauges and valves. During an interview at the time of record review, the Maintenance Director stated no monthly checks of the sprinkler system's gauges or valves were recorded. 3.1-19(b)			
K 0355 SS=B Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the kitchen were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This	K 0355	1.It is, and always has been the intent of Timbercrest that all our fire extinguishers are secured by either an appropriate bracket, located in a cabinet or within a recess in the wall. Immediate corrective action taken was a work order was issued to secure the fire extinguisher. 2.No other concerns regarding this standard were identified during the Life Safety Survey. 3.The monthly preventative maintenance task for fire extinguishers was updated adding “Safely Secured & Stable”. 4.The Director of Maintenance	12/07/2017

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	deficient practice was not in a resident care area but could affect staff in the Crestwood basement. Findings include: Based on observations during a tour of the facility with the Maintenance Director, on 11/07/17 at 11:25 a.m. the ABC portable fire extinguisher located in the Crestwood elevator mechanical room was sitting on the floor. Based on interview at the time of observation, the Maintenance Director stated the extinguisher was sitting on the floor because the mounting device on the extinguisher was broken. 3.1-19(b)		or designee will review preventative maintenance work orders for completeness and concerns will be brought to the attention of the Associate Director and Timbercrest's QAPI, during QAPI-safety meeting. Preventative maintenance task shall be ongoing for a period of no less than 3 years. 5.Compliance Date: 12/7/2017. Timbercrest requests desk review/ paper compliance for plan of correction submitted for K 355.	
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 interview and observation; the facility failed to ensure 1 of 1 community rooms in the Crestwood hall that was open to the corridor was equipped with smoke detection. LSC 19.3.6.1(1) states	K 0361	1.It is, and always has been the intent of Timbercrest that all areas, greater than 50 sq. ft., off a corridor are properly equipped with smoke detection devices and alarms. Immediate corrective action taken was Nowak,	12/07/2017

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	smoke compartments protected throughout by an approved supervised automatic sprinkler system in accordance with 19.3.5.8 shall be permitted to have spaces that are unlimited in size and open to the corridor and area, provided: (a) the spaces are not used for patient sleeping rooms, treatment rooms, and hazardous areas. (b) The corridors onto 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, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) the open space is protected by an electrically supervise automatic smoke detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses station or similar space. (d) The space does not to obstruct access to required exits. This deficient practice could affect up to 20 residents in the Crestwood hall. Findings include: Based on observations during a tour of the facility with the Maintenance Director and on 11/07/17 at 12:10 p.m., the "fireplace room "in the Crestwood hall was open to the corridor and was not		Timbercrest's fire protection service contractor, was contacted to install smoke detector. 2.No other concerns regarding this standard were identified during the Life Safety Survey. 3.New construction areas will be verified to be complaint with this standard, by the Fire Marshall and Timbercrest's Director of Maintenance. 4.Due to the uniqueness of this concern and that there are no other areas needing a smoke detector within our current structure nor any planned new construction, a process for continuing monitoring is not needed. 5.Compliance Date: 12/7/2017. Timbercrest requests desk review/ paper compliance for plan of correction submitted for K 361.	

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	equipped with smoke detection or located to allow direct supervision. Based on interview at the time of observations, the Maintenance Director stated the "fireplace room" was open to the corridor and was not equipped with a smoke detector. 3.1-19(b)			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. NFPA 101 2012 edition 19.3.7.3 requires smoke barriers to be constructed in	K 0372	1.It is, and always has been the intent of Timbercrest that all areas of health care occupancy are separated and maintained to ensure 2 hours of fire resistance. Timbercrest issued a work order for holes to be patched. 2.All other fire barriers were inspected during the Life Safety Survey process, no other areas of	12/07/2017

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	accordance with LSC 8.5. 8.5.2.2 States smoke barriers required by this code shall be continuous from outside wall to outside wall, from floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 Requires penetrations for cable, conduit, pipe, or wire...of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. This deficient practice 30 residents in three smoke compartments. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 11/07/17 between 1:00 p.m. and 1:30 p.m. the following smoke barrier walls had unsealed penetrations: a) Above the ceiling tiles of the 200 hall smoke barrier wall there was an unsealed half inch penetration and a two inch gap around conduits. b) Above the ceiling tiles of the 300 hall smoke barrier that ran along the kitchen contained four unsealed one inch holes. Based on interview at the time of observation, the Maintenance Director provided the measurements of the penetrations, gaps and holes. 3.1-19(b)		concern were identified. 3.Checking smoke barriers was added to monthly inspection of all fire barriers as a preventive maintenance tasks, this inspection will in conducted in conjuction with the inspection to ensure astragal are in place. 4.The Director of Maintenance or designee will review preventative maintenance work orders for completeness and concerns will be brought to the attention of the Associate Director and Timbercrest's QAPI, during QAPI-safety meeting. Preventative maintenance task for shall be ongoing for a period of no less than 3 years. 5.Compliance Date: 12/7/2017. Timbercrest requests desk review/ paper compliance for plan of correction submitted for K 372.	

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K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes observed were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect over 20 residents in one smoke compartment. Findings include: Based on observation during a tour of the facility with the Lead Maintenance Technician on 11/07/17 at 1:10 p.m., the electrical junction box above the ceiling tiles by the 200 hall smoke wall was without a cover and had exposed	K 0511	1.It is, and always has been the intent of Timbercrest that all electrical junction boxes are in safe and operating condition. Timbercrest issued a work order for a cover to be placed on junction box. Upon further review it was determined that junction box was used for communication cables used by Nowak, Timbercrest's fire protection service contractor. Nowak was contacted install a cover. 2.During the Life Safety Survey process, no other areas of concern were identified. 3.A preventative maintenance task to check electrical junction boxes was created within Timbercrest's work order system. 4.The Director of Maintenance or designee will review preventative maintenance work orders for completeness and concerns will be brought to the attention of the Associate Director and Timbercrest's QAPI, during QAPI-safety meeting. Preventative maintenance task for checking junction boxes shall be ongoing for a period of no less than 3 years.	12/07/2017

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	electrical wiring. Based on interview at the time of the observations, the Lead Maintenance Technician agreed the aforementioned electrical junction box was not provided with a cover. 3.1-19(b)		5.Compliance Date: 12/7/2017. Timbercrest requests desk review/ paper compliance for plan of correction submitted for K 511.	
K 0531 SS=C Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 Based on record review and interview, the facility failed to maintain testing of 1 of 1 elevator firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in	K 0531	1.It is, and always has been the intent of Timbercrest that all fire test are conducted monthly on elevators located in health care. Immediate action taken was to relocate log and have placed at the elevator. 2.During the Life Safety Survey	12/07/2017

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	155740	A. BUILDING 01 B. WING	11/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREST CHURCH OF THE BRETHREN HOME	2201 EAST ST NORTH MANCHESTER, IN 46962

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	accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice would affect all occupants. Findings include: Based on records review with the Maintenance Director on 11/07/17 at 11:18 a.m., the form titled "Fire Service Test Log" indicated testing for the elevator firefighter recall last occurred in January 2017. Based on interview at the time of record review, the Maintenance Director stated the testing form was changed and did not know where the new form was located that would show testing after January 2017. 3.1-19(b)		process, no other areas of concern were identified. 3.Maintenance department was re-educated on the importance of maintaining documentation of fire test within the elevator as well as the keeping completed work orders. 4.The Director of Maintenance or designee will review preventative maintenance work orders for completeness and concerns will be brought to the attention of the Associate Director and Timbercrest's QAPI, during QAPI-safety meeting. Preventative maintenance task for checking junction boxes shall be ongoing for a period of no less than 3 years. 5.Compliance Date: 12/7/2017. Timbercrest requests desk review/ paper compliance for plan of correction submitted for K 531.	
K 0541 SS=E Bldg. 01	NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new			

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	chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82			
	Based on observation, records review, and interview, the facility failed to ensure 1 of 1 laundry shoots was protected from the corridor. NFPA 82, 5.2.4.1.1 states waste and linen chutes shall terminate or discharge directly into a room having a minimum fire resistance rating not less than that specified for the chute. 5.2.4.1.2 states openings into such a room or compartment shall be protected by approved self-closing fire doors having a minimum fire protection rating not less than specified for the chute. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation during a tour of the facility with the Maintenance Director on	K 0541	1.It is, and always has been the intent of Timbercrest that all laundry chutes have automatic closing doors. Immediate action taken was a replacement door was ordered and work order issued for installation upon arrival. 2.Timbercrest only has one location within its licensed health care area with a laundry chutes. 3.A preventative maintenance task to check the automatic functioning of the laundry chute was created within Timbercrest's work order system. 4.The Director of Maintenance or designee will review preventative maintenance work orders for completeness and concerns will be brought to the attention of the Associate Director and Timbercrest's QAPI, during QAPI-safety meeting. Preventative maintenance task	12/07/2017

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	11/07/17 at 12:48 p.m., the linen shoot room contained a linen shoot with a fire rated door that was not self-closing nor a corridor door that had documentation of a fire rating. Based on records review, the facility construction plans rated the line shoot constructed with a two hour protection. Based on interview at the time of observation, the Maintenance Director agreed the linen shoot door was a rated fire door but was not self-closing and the fire rating on the corridor door could not be determined. 3.1-19(b)		for checking laundry chutes shall be ongoing for a period of no less than 3 years. 5.Compliance Date: 12/7/2017. Timbercrest requests desk review/ paper compliance for plan of correction submitted for K 541.	
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan 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 1 of 1 written emergency fire safety plan that incorporated all items listed in NFPA	K 0711	1.It is, and always has been the intent of Timbercrest that it's evacuation and relocation plans provided complete information and instructions for how to respond to fire alarms and safe	12/07/2017

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	101, Section 19.7.2.2. 1. Use of alarms. 2. Transmission of alarms 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. This deficient practice affects all residents, staff and visitors in the event of an emergency. Findings include: Based on record review with the Maintenance Director on 11/07/17 at 12:12 p.m., the facility's fire safety plan and procedures that was located at the main nurses station did not address the response to the battery operated smoke detectors in the resident sleeping rooms Also, the facility did not provided information indicating locations of smoke/fire barriers nor identified cross corridor doors that could be mistaken as smoke/fire barrier doors. Based on interview at the time of record review, the Maintenance Director agreed the aforementioned information was missing.		locations for residents in case of a fire emergency. 2.During the Life Safety Survey process, no other areas of concern were identified. 3.Policy for responding to smoke detectors was separated from fire response policy and procedures. A map noting smoke barriers and identifying doors to common areas that are not smoke barriers will be created, distributed to all department directors, health care nursing staff and hung in departmental locations within in health care. 4.Timbercrest's QAPI-safety committee will reviewed its evacuation and relocation plan annually, as needed, and update accordingly. 5.Compliance Date: 12/7/2017. Timbercrest requests desk review/ paper compliance for plan of correction submitted for K 711.	

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	3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs			

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	cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room doors was provided with a precautionary sign readable from 5 feet of the door. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 11/07/17 at 12:30 p.m., the oxygen storage/trans-filling room contained 'E' type oxygen cylinders. The door to the room was not provided with a precautionary sign stating oxidizing gasses were stored in the room. Based on interview at the time of observation, the Maintenance Director agreed there was no precautionary sign on the door and the room was used for storage of oxygen cylinders. 3.1-19(b)	K 0923	1.It is, and always has been the intent of Timbercrest that areas utilized for oxygen storage are properly identified and marked. Immediate action taken was a temporary notification sign was created and posted in the appropriate location. 2.Timbercrest only has one location within licensed health care where oxygen is stored. 3.A work order was to order and post upon arrival a permanent sign indicating oxygen storage. 4.The Director of Maintenance or designee will ensure sign is in place. Audits will be conducted monthly for 3 months, until a compliance rate of 95% is obtained, and then quarterly, thereafter for a 12 month period. If any audit should be reveal a compliance rate of less than 95%, auditing will return to a monthly basis until 95% is obtained. Audit results will be reported through Timbercrest's QAPI process during QAPI-safety meeting. 5.Compliance Date: 12/7/2017. Timbercrest requests desk review/ paper compliance for plan of correction submitted for K 923.	12/07/2017