

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

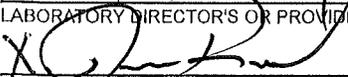
PRINTED: 12/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
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NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
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(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
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F 000	INITIAL COMMENTS A standard health survey was conducted 12/06-12/08/11. A Life Safety Code Survey was conducted on 12/06/11. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct before remedies would be imposed.	F 000	The submission of this plan of correction does not constitute an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This plan is being submitted because it is required by law.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy related to Physical Restraints, it was determined the facility failed to appropriately monitor and release restraints for one (1) of twenty (20) sampled residents (Res #9). Resident #9 had an alarming seat belt in place during two meal observations, on 12/07/11, with no evidence the seat belt was removed according to the plan of care. The findings include: Review of the facility policy related to Physical Restraints, dated October 2010, revealed the purpose was to establish a systematic process for the assessment of, implementation of, use of and evaluation of the use of a Physical Restraint...Assessment forms for restraints include: Restraint Assessment; Restraint Decision Tree; Restraint Reviews; and Restraint	F 221	Release of resident's #9 seat belt was monitored for the remainder of the survey. The care plan for resident s#9 was revised on 12/16/11 by the ADON to reflect the plan to release the seat belt at meal time. All residents' records will be audited by the Unit Coordinators to ensure all that all restraint assessments, device decision trees and restraint reviews are current and that all restraints have release plan as indicated. The care plans and NA care plans will be reviewed and updated as indicated to ensure the release plans are included. This will be completed by 1/6/12.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE X NHA	(X6) DATE 12.20.11
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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.

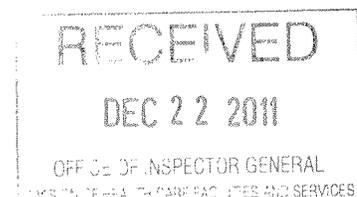
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F 221	<p>Continued From page 1</p> <p>Information for Resident/Family. In addition, review of the Restraint Review form contained in the policy, identified a restraint release plan, which noted the seat belt was to be released at mealtimes and during incontinence care.</p> <p>Record review revealed the facility admitted Resident #9, on 06/19/07, with diagnoses of Alzheimer Disease, Parkinson's, and Dementia with Behavior. Review of the Comprehensive Assessment, dated 04/29/11, revealed the facility assessed the resident as cognitively impaired, and was not interviewable. Approaches for Resident #9's plan of care related to the potential for harm/injury, determined the alarming seat belt restraint was to be checked every two hours, and released, with repositioning of the resident, and removal of the seat belt at meal time.</p> <p>Observation of Resident #9, on 12/07/11 at 8:00 AM and 12:20 PM, during the meal service, revealed the resident sitting at the dining table with the alarming seat belt secured in place. Attempts at interviewing the resident was unsuccessful, and the resident was unable to remove the seat belt. Continued observation throughout both meal services revealed the seat belt was not released.</p> <p>Review of the initial restraint assessment revealed the facility assessed the resident on 11/09/09 for a self-releasing alarming seat belt with the medical symptom identified to be decrease safety awareness secondary to Dementia. Review of the device decision tree form revealed the facility had assessed the alarming seat belt as a restraint and an enabler. Review of the Restraint Reviews, dated 07/13/11</p>	F 221	<p>Nursing staff will be re-educated on the practice of releasing restraints per residents care plan and following the care plan for each resident. This will be completed by the Staff Development Coordinator 1/6/12. All newly hired employees will be educated during the orientation process.</p> <p>The DON will review NA Care plans weekly for 4 weeks then within the first week of each month for 3 months to ensure the release plan for the resident's restraint are included. The DON will check each resident identified at meals daily for 2 weeks then weekly for 4 weeks to ensure the restraint is being released per the resident's plan of care.</p> <p>These audits will be reported to the facility QA Committee no less than quarterly for review.</p>	1-6-12	



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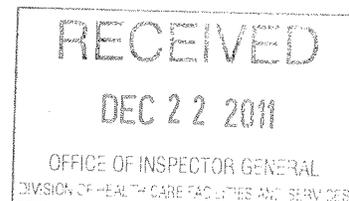
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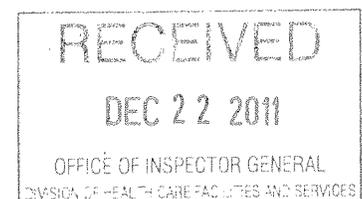
F 221	<p>Continued From page 2 and 09/27/11, revealed the restraint release plan was to include releasing at meals, and with incontinent care.</p> <p>Interview with CNA #1, on 12/07/11 at 12:22 PM, revealed the resident did not have the seat belt released during the two meals and this should have been done. CNA #1 stated she normally worked night shift and didn't know to release the seat belt. However, review of the CNA care plan for Resident #9 revealed the facility failed to include the instructions on the CNA care plan to release the seats belts during meals.</p> <p>Interview with the Unit Manager LPN on the Blue Unit, on 12/08/11 at 10:45 AM, revealed she had been in this position for one month and stated any nurse receiving new orders for restraints should complete the care plan update, as well as the certified nursing assistant (CNA) care plan. The Assessment Coordinator, DON, and Unit Managers were responsible for monitoring and ensuring that all new physician order updates are put on the CNA Care Plans; however, she was responsible, as Unit Manager, for monitoring this was completed. In addition, the Unit Manager revealed on admission, the decision tree, and initial restraint assessment, with family education on risk/benefits, should be completed for any resident with restraints. Also, the UM stated restraints are reviewed quarterly, annually, and with any new changes with the comprehensive assessment.</p> <p>Interview with the Administrator, on 12/08/11 at 11:00 AM, revealed each Unit Coordinator completed restraint assessments and completed the decision tree with any new order for restraints.</p>	F 221		
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F 221	Continued From page 3 The Administrator confirmed the interview with the Unit Manager relating to the updating of the Comprehensive Care Plans and CNA Care Plans, monitoring is required by the DON, or Unit managers to ensure compliance. The Administrator stated the restraint should have been released for Resident #9 and the CNA care plan updated.	F 221			



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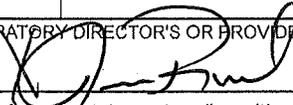
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type II (111)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator installed in 1993. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 12/06/11. Hart County Health Care Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred four (104) beds and the census was one hundred (100) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>Smoke barriers had holes repaired on 12/12/11 by facility maintenance staff. The repairs were to fire walls at the top of 100 hall, the back part of 100 hall, the front part of 400 hall, the rear of 400 hall and 700 hall.</p> <p>Maintenance staff completed a 100% review of all fire walls by 12/16/11 to ensure there were no more deficient areas.</p> <p>Maintenance staff will conduct monthly reviews of the fire walls and report this to the safety committee. Any deficient area will be repaired at this time.</p> <p>The safety committee chairman will report results of audit to the QA Committee on a quarterly basis.</p>	1-6-12
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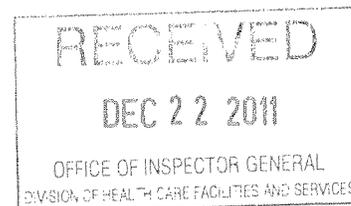
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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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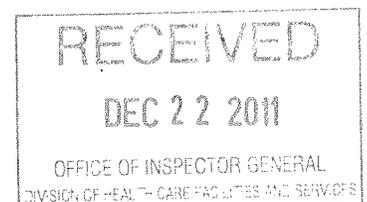
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K 000	Continued From page 1	K 000		
K 025 SS=F	<p>Deficiencies were cited with the highest deficiency identified at " F " level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire 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>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred four (104) beds with a census of one hundred (100) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/06/11 between 1:30 PM and 2:00 PM, with the Assistant Maintenance Director, and the Housekeeping and Laundry Supervisor</p>	K 025		



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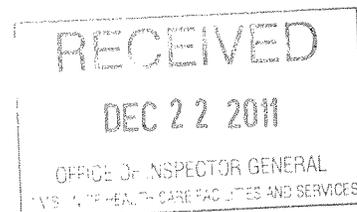
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K 025	<p>Continued From page 2</p> <p>revealed the smoke partitions extending above the ceiling in all the smoke barriers to be penetrated by pipes and wires The spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke.</p> <p>Interview, on 12/06/11 between 1:30 PM and 2:00 PM, with the Assistant Maintenance Director, and the Housekeeping and Laundry Supervisor revealed they were not aware of the penetrations.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 	K 025		



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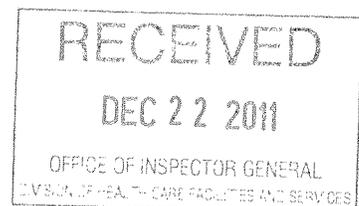
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K 025 K 050 SS=F	Continued From page 3 2. Be made by an approved device designed for the specific purpose. NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff 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 This STANDARD is not met as evidenced by: Based on interview and fire drill review it was determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred four (104) beds with a census of one hundred (100) on the day of the survey. The findings include: Fire Drill review, on 12/06/11 at 8:00 AM, with the Assistant Maintenance Director revealed the fire drills were not being conducted at unexpected times under varied conditions. Fire drills were being conducted as follows: First Shift	K 025 K 050	The following schedule has been devised by maintenance staff to ensure fire drills take place on a random basis. 1/12 at ~830AM 4/12 at ~11AM 7/12 at ~130 PM 10/12 at ~230PM 2/12 at ~330PM 5/12 at ~630PM 8/12 at ~830PM 11/12 at ~10PM 3/12 at ~12AM 6/12 at ~2AM 9/12 at ~3AM 12/12 at ~6AM The maintenance director will provide a copy of the most recent completed fire drills to the safety committee for review. The safety committee chairman will share results of fire drills with QA Committee quarterly.	1-6-12



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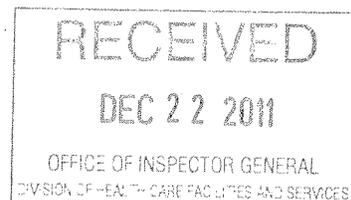
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K 050	Continued From page 4 10/26/11 @ 9:10 AM 7/25/11 @ 9:45 AM 4/30/11 @ 1:30 PM 1/25/11 @ 9:50 AM Second Shift 11/29/11 @ 3:00 PM 8/17/11 @ 3:20 PM 5/25/11 @ 3:15 PM 2/25/11 @ 3:10 PM Third Shift 9/30/11 @ 5:45 AM 6/27/11 @ 6:10 AM 3/11/11 @ 6:04 AM 12/17/10 @ 6:10 AM Interview, on 12/06/11 at 8:00 AM, with the Assistant Maintenance Director revealed he was unaware the fire drills were not being conducted as required. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8	K 070		



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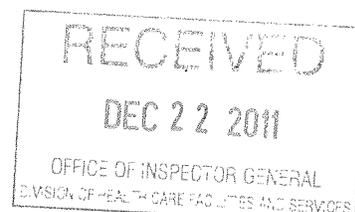
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K 070	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred four (104) beds with a census of one hundred (100) on the day of the survey. The findings include: Observation, on 12/06/11 at 1:20 PM, with the Assistant Maintenance Director, and the Housekeeping and Laundry Supervisor revealed a portable space heater located in the Staff Development Office. Interview, on 12/06/11 at 1:20 PM, with the Assistant Maintenance Director, and the Housekeeping and Laundry Supervisor revealed they were aware the heater was not permitted in patient care areas, but not aware the heating element could not exceed, 212°F (100°C) when used in nonsleeping staff and employee areas. Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where	K 070	The heater has been removed from the staff development office by maintenance staff. The maintenance supervisor will complete a 100% review offices by 12/23/11 that any heater in place has the paperwork stating it does not exceed 212 degrees. The maintenance supervisor will conduct monthly audits of offices to ensure if a heater is present it has the necessary paperwork in place. The results of these audits will be reviewed monthly with the safety committee. The safety committee chairman will share results quarterly with the QA Committee.	12-23-11 12-23-11	



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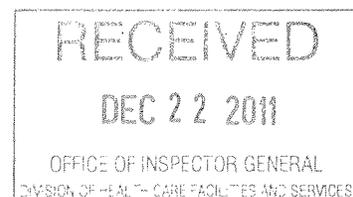
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/06/2011
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
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K 070 K 130 SS=E	Continued From page 6 the heating elements of such devices do not exceed 212°F (100°C). NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred four (104) beds, with a census of one hundred (100) on the day of the survey. The findings include: Observation, on 12/06/11 between 9:00 AM and 2:00 PM, with the Assistant Maintenance Director, and the Housekeeping and Laundry Supervisor revealed an unapproved lock (slide bolt type) was installed on the egress side of the whirlpool room, men's and women's shower rooms in the Pink and Blue Unit, and the Social Services Office. Interview, on 12/06/11 between 9:00 AM and 2:00 PM, with the Assistant Maintenance Director, and the Housekeeping and Laundry Supervisor revealed they were aware of the locks, but not aware they were prohibited. Observation, on 12/06/11 at 1:39 PM, with the Assistant Maintenance Director, and the	K 070 K 130	The slide locks were removed from the doors on 12/7/11. Maintenance staff will conduct a 100% audit of the facility to ensure no slide locks were present by 1/6/12. Maintenance staff will conduct a 100% audit of the facility monthly to ensure no slide locks are present. The maintenance director will provide a copy of the most recent slide lock audit to the safety committee for review. The safety committee chairman will share results audit with QA Committee quarterly.	1-6-12



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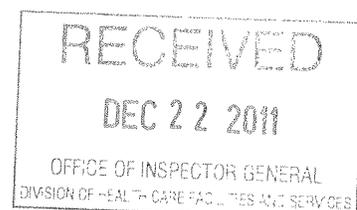
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K 130	Continued From page 7 Housekeeping and Laundry Supervisor revealed heavy lint build up in the top, burner area, of the two (2) dryers located in the Laundry Room. Interview, on 12/06/11 at 1:39 PM, with the Assistant Maintenance Director, and the Housekeeping and Laundry Supervisor revealed the Maintenance Staff was responsible for cleaning the top of the dryers around the burners monthly, but confirmed the lint accumulated in the top of the dryers was significant. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4	K 130	The lint from the dryer was cleaned on 12/7/11 by maintenance staff. The dryer is checked daily for lint build up by laundry staff. The maintenance staff cleans will clean this area weekly. Laundry staff will be instructed by the Laundry supervisor by 1/6/12 to notify maintenance staff when the dryer needs additional cleaning before the regularly scheduled cleaning. Maintenance staff will record every time the dryer is cleaned.	
K 154 SS=F	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 This STANDARD is not met as evidenced by: Based on interview and facility policy and procedure review, the facility failed to develop a fire watch policy to ensure the safety of occupants of the building in case the sprinkler system was out of service. The deficiency had	K 154	The maintenance staff will share results of the cleaning schedule with the safety committee. At this time the safety committee will determine if a new cleaning schedule is needed. The safety committee chairman will share results quarterly with the QA Committee.	1-6-12



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K 154	Continued From page 8 the potential to affect five (5) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred four (104) beds with a census of one hundred (100) on the day of the survey. The findings include: Policy and Procedure review, on 12/06/11 at 9:30 AM, with the Assistant Maintenance Director, and the Housekeeping and Laundry Supervisor revealed the facility had no written fire watch policy. Interview, on 12/06/11 at 9:30 AM, with the Assistant Maintenance Director, and the Housekeeping and Laundry Supervisor revealed they thought the facility had a written policy. Reference; NFPA 101 (2000 edition) 9.7.6* Sprinkler System Shutdown. 9.7.6.1 Where a required automatic sprinkler system is out of service 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 sprinkler system has been returned to service.	K 154	The Fire Watch Policy was placed at each nurses station on 12/7/12. The Housekeeping Supervisor is conducting an inservice with staff in regards to the policy. This will be completed by 1/6/12. The Housekeeping Supervisor will conduct monthly audits to determine the policy is still at each nurses station. The results of the audit will be shared with the safety committee. The safety committee chairman will share results quarterly with the QA Committee.	
K 155 SS=F	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	K 155		



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K 155	Continued From page 9 This STANDARD is not met as evidenced by: Based on interview and fire watch review, the facility failed to develop a fire watch policy to ensure the safety of occupants of the building in case the fire alarm system is out of service. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred four (104) beds with a census of one hundred (100) on the day of the survey. The findings include: Policy and Procedure review, on 12/06/11 at 9:30 AM, with the Assistant Maintenance Director, and the Housekeeping and Laundry Supervisor revealed the facility had no written fire watch policy. Interview, on 12/06/11 at 9:30 AM, with the Assistant Maintenance Director, and the Housekeeping and Laundry Supervisor revealed they thought the facility had a written policy. Reference; NFPA 101 (2000 edition) 9.6.1.8* Where a required fire alarm system is out of service 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.	K 155	The Fire Watch Policy was placed at each nurses station on 12/7/12. The Housekeeping Supervisor is conducting an inservice with staff in regards to the policy. This will be completed by 1/6/12. The Housekeeping Supervisor will conduct monthly audits to determine the policy is still at each nurses station. The results of the audit will be shared with the safety committee. The safety committee chairman will share results quarterly with the QA Committee.	1-6-12

