STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152600	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 05/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS FRANKFORT	1300 S JACKSON ST FRANKFORT, IN 46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification Survey for an End Stage Renal Disease (ESRD) facility was conducted by the Indiana State Department of Health in accordance with 42 CFR 494.60(d). Survey Date: 05/02/114 and 05/08/14 Facility Number: 007333 Provider Number: 152600 AIM Number: 100269080A Surveyor: Bridget Brown, Life Safety Code Specialist At Life Safety Code survey, Liberty Dialysis Frankfort was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 494.60(d), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies. This facility was located on the east wing on the third floor of a three story fully sprinklered building determined to be of Type I (332) construction. The facility has a fire alarm system with hard wired	K010000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	smoke detection in the corridors. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010048	416.44(b)(1) LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 20.7.1.1, 21.7.1.1 1. Based on interview and record review, the facility failed to provide a facility fire plan for the protection of 6 of 6 dialysis patients. This deficient practice affects all occupants. Findings include: Based on interview with Nurse # 1 on 05/02/14 at 12:45 p.m., Nurse # 1 could not provide a facility fire plan for review. She said at the time of interview, she did not know if the facility had its own fire plan. She said she followed the procedures of the hospital in which the facility was located. She said she did not have a hospital fire plan for reference and immediately called a supervisor who did not provide her with the information needed. A hospital fire plan was provided for review by the hospital plant	K010048	The Technical Supervisor/Clinical Manager educated all staff members by 5/5/14 on the following: · Facility Specific Fire Safety Plan, FMS-CS-IC-II-130-013D1 · Guidelines for Performing a Fire Watch Policy, FMS-CS-IC-II-130-016A · Fire Watch Log, FMS-CS-IC-II-130-016D1 The Facility Specific Fire Safety Plan (see attached) was posted at the Nursing Station, the Water Treatment Area, and the Clinical Manager's office by the Director of Operations on 5/2/14. The Technical Supervisor/Clinical Manager will educate all staff members by 6/6/14 on the Hospital Fire Plan and Interim Life Safety Measures Plan. The Director of Operations/Clinical Manager will ensure ongoing training on an annual basis utilizing the QAI tracking form. All training records are on file at the	06/06/2014

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	services supervisor on 05/08/14 at 11:45 a.m. The plan did not identify the type of fire extinguishers for use, evacuation of the facility and any special needs of dialysis patients. 2. Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 6 of 6 patients in the event the fire alarm system or automatic sprinkler system has to be placed out of service for four hours within a 24 hour period. LSC 9.6.1.8 requires where a fire alarm system is out of service for more than four 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. This deficient practice could affect all occupants. Findings include: Based on interview with Nurse # 1 on 05/02/14 at 12:15 p.m., she did not know what procedure to follow in the event the fire alarm or sprinkler system was out of service. She said she had no Policy manual to reference and presumed the hospital maintenance staff would know if		facility. All findings will be presented to the QAI Committee	

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	the systems were out of service and what action was needed. A review of the hospital Interim Life Safety Measure (ILSM) policy and procedure with the hospital plant supervisor was done on 05/08/14 at 1:00 p.m. The hospital plant supervisor said the policy was the only record for initiating fire watch procedures. The ILSM addressed fire watch procedures to be implemented when interruptions occurred during construction or renovation to the hospital. The policy did not provide for notifying ISDH, documentation of the fire watch rounds and identifying staff dedicated solely to performing the fire watch. The plant supervisor acknowledged at the time of record review, this ILSM policy did not include all elements required for the initiation of a fire watch, identify the alternative to evacuate and specific procedures as they might apply to the dialysis facility.			
K010050	416.44(b)(1) 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. 20.7.1.2, 21.7.1.2 Based on record review and interview, the facility failed to provide evidence fire drills were conducted quarterly on each	K010050	Fire drills were held on 3/21/14, 3 of 3 shifts and 3/22/14, 2 of 2 shifts, to include simulated activation of the fire alarm and staff members' specific roles. All	05/08/2014

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	shift for 2 of the last 4 quarters which included evidence all staff had trained and participated. LSC 4.7.2 requires suitable procedures to ensure all persons subject to the drill participate. This deficient practice could affect all occupants. Findings include: Based on interview with Nurse # 1 on 05/02/14 at 12:00 p.m., she could not provide evidence fire drills were conducted to train all staff. She said she thought there were records in a locked cabinet for which she had no key. She immediately called a supervisor and reported the documentation could not be provided. She said the facility employees participated in hospital fire drills. A list of the dialysis facility staff was provided by the facility dietician on 05/08/14 at 12:10 p.m. A review of hospital fire drill records provided by the hospital plant supervisor on 05/08/14 at 12:15 p.m. was compared with the dialysis facility's staff list. The records evidenced the participation of only Nurse # 1 during fire drills conducted during the second quarter of 2013 and the first quarter of 2014. There was no other training record to evidence all dialysis facility staff were trained in special procedures in the event of fire.		staff members did participate. (This documentation was not readily available during the survey – see attached) The Clinical Manager provided education to all staff members by 5/5/14 on the following: · Fire Drill Policy, FMS-CS-IC-II-130-013A · Fire Drill Procedure, FMS-CS-IC-II-130-013C · Facility Specific Fire Safety Plan, FMS-CS-IC-II-130-013D1 The Director of Operations/Clinical Manager will ensure that fire drills are completed (inclusive of all staff) quarterly utilizing the QAI tracking form. Training documentation is on file at the facility. The Director of Operations/Clinical Manager will report all findings to the QAI Committee.	

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K010130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview, the facility failed to ensure 4 of 4 smoke detectors had been sensitivity tested. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity	K010130	The Director of Operations and Technical Program Manager contacted the Hospital Plant Manager on 5/8/14 regarding documentation of the sensitivity testing of the smoke detectors. The Hospital Plant Manager verified that smoke detector sensitivity testing was completed on 7/20/12. The Hospital Plant Manager has scheduled smoke detector sensitivity testing to be completed by 6/6/14. The Technical Supervisor/designee will ensure that all documentation regarding smoke detector sensitivity testing is at the facility utilizing the QAI tracking form. The Director of Operations/Clinical Manager will report all findings to the QAI Committee.	06/06/2014

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	test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. This deficient practice affects all occupants. Findings include: Based on a review of the 09/09/13 Sensitivity Testing report with the hospital plant supervisor charged with maintaining the dialysis facility's fire protection systems on 05/08/14 at 1:15 p.m., the report was incomplete. The Table of contents noted Sensitivity Test Results on page 10. The location and the range within which each detector should test was documented but no sensitivity results were listed, and nothing was			

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	written to identify whether smoke detectors passed or failed the testing. The plant supervisor said at the time of record review, he had no other record to evidence the dialysis facility's smoke detectors were within their normal sensitivity ranges.			