

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>1a</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2015
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NAME OF PROVIDER OR SUPPLIER FAIRWAY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
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K 000 Bldg. 1a	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/24/15</p> <p>Facility Number: 004700 Provider Number: 155741 AIM Number: 100266630</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Fairway Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a partial basement was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to</p>	K 000		

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

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

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K 038 SS=E Bldg. 1a	<p>the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 53 and had a census of 25 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached storage shed.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/31/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure the ceiling in the means of egress through 1 of 6 exits met or exceeded the minimum headroom. LSC 7.1.5 states the means of egress shall be designed and maintained to</p>	K 038	<p>whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice;</p> <p>Please see waiver request attached. The ceiling height in</p>	04/10/2015

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	<p>provide headroom and shall be not less than 7 feet 6 inches.</p> <p>Exception No. 1: In existing buildings, the ceiling height shall not be less than 7 feet (2.1 m) from the floor with no projection below a 6 feet 8 inches nominal height from the floor.</p> <p>This deficient practice could affect 25 residents, staff or visitors using the Main Dining Room exit to the back patio.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Director during a tour of the facility from 11:25 a.m. to 12:30 p.m. on 03/24/14, the Main Dining Room exit which leads to the patio is marked as a facility exit with an exit sign. The ceiling height in the means of egress from the Main Dining Room exit in the vending machine area to the back patio measured 6 feet 8 3/4 inches. Based on interview at the time of observation, the Maintenance Director acknowledged the ceiling height in the aforementioned means of egress was less than 7 feet.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the maximum riser height, minimum tread depth and</p>		<p>means of egress will be atleast 7 feet, existing stairs will be provided with at least a minimum heightof stair risers 7.5 inches, minimum thread depth of 11 inches and minimum headroom of at least 6 feet 8 inches to meet code; all to be completed when facility construction permits are approved.</p> <p>how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <p>All exit doors have been measured by Maintenance Director to ensure doors meets height requirements. Facility has no other staircases. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Additional structures will be monitored by Maintenance Director to ensure ceiling height requirements are met. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Additional structure will be monitored by Maintenance to ensure ceiling height requirements are met. by what date the systemic changes will be completed See waiver requested.</p>	

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	<p>minimum headroom for 1 of 1 stairs met the requirements of Table 7.2.2.2.1(b). Table 7.2.2.2.1(b) requires existing stairs be provided with a maximum height of stair risers of 7.5 inches, minimum tread depth of 11 inches and minimum headroom of 6 feet 8 inches. This deficient practice could affect three staff and visitors in the basement.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 11:25 a.m. to 12:30 p.m. on 03/24/14, the following was noted for the basement stairwell:</p> <p>a. a four inch in diameter sprinkler pipe projected ten inches into the 48 inch width of the stairwell and provided four feet of headroom at the bottom two stairs.</p> <p>b. tread depth of 8 1/2 inches.</p> <p>c. riser height measured a minimum 8 3/4 inches.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the basement stairwell headroom, tread depth and riser height measurements.</p> <p>3.1-19(b)</p>			

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K 050 SS=F Bldg. 1a	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to document fire drills conducted on the third shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" and "Monthly Fire Drill Report" documentation with the Maintenance Director during record review from 9:25 a.m. to 11:25 a.m. on 03/24/15, documentation of a fire drill conducted on the third shift in the third quarter of 2014 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of a fire drill conducted on the third shift in the third quarter of 2014 was not available for review.</p>	K 050	<p>whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice;</p> <p>Documentation regarding firedrills are current. howother residents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken;</p> <p>Allresidents, staff and visitors have the potential to be affected. Fire drillswill be conducted by Maintenance Director for all four quarters on each shifthroughout the year then verified by the Executive Director.</p> <p>whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur;</p> <p>MaintenanceDirector will complete the Monthly Fire Drills Reports and monitor weekly</p>	04/10/2015			

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K 052 SS=F Bldg. 1a	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review, observation and interview; the facility failed to document annual functional testing of 50 of 50 fire alarm system smoke detectors. NFPA</p>	K 052	<p>times4 weeks and monthly times 6. The results of this audit will be reviewed by the Safety committee monthly overseen by the Executive Director. If threshold of 100% is not achieved an action plan will be developed. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and</p> <p>Maintenance Director will complete the Monthly Fire Drills Reports and monitored monthly and report to the Safety Committee. The results of this audit will be reviewed by the Safety committee monthly overseen by the Executive Director. If threshold of 100% is not achieved an action plan will be developed. By what date the systemic changes will be completed. April 10, 2015</p> <p>K52 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p>	04/10/2015

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	<p>72, 7-3.2 refers to fire alarm component testing frequencies in Table 7-3.2 which requires an annual functional test of smoke detector initiating devices. Section 7-5.2 requires a permanent record of all inspections, testing and maintenance shall be provided that includes information requested in Figure 7-5.2.2. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director during from 9:25 a.m. to 11:25 a.m. on 03/24/15, documentation of annual functional testing of all fire alarm system smoke detectors within the most recent twelve month period was not available for review. Review of SafeCare's "Inspection and Testing Form" dated 05/05/14 stated one manual fire alarm box and one smoke detector passed functional testing but did not identify the location of either initiating device. Review of Vanguard Alarm Services "Periodic Fire Alarm Inspection and Testing Report" dated 08/19/14 and 11/28/14 each stated there were a total of 50 fire alarm system smoke detectors in the facility but these smoke detectors were not functional tested. In addition, Vanguard's "Inspection and Testing</p>		<p>Functional testing of fire alarms completed by Vanguard.</p> <p>how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <p>All residents, staff and visitors have the potential to be affected by deficient practice. Functional testing of fire alarm completed by Vanguard. Maintenance Director will ensure Inspection and testing of fire alarm system are conducted annually by contractor then verified by Executive Director. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>Maintenance Director will ensure Inspection and testing of fire alarm system are conducted annually by contractor then verified by Executive Director that functional test have been completed.</p> <p>how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and</p> <p>- Maintenance Director will complete the Continuous Quality Improvement tool on</p>				

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K 072 SS=E Bldg. 1a	<p>Certificate" dated 01/21/15 also stated there were a total of 50 fire alarm system smoke detectors in the facility but these smoke detectors were not functional tested. Based on interview at the time of record review, the Maintenance Director stated the facility switched fire alarm system inspection contractors during the course of 2014 and acknowledged documentation of annual functional testing of all fire alarm system smoke detectors within the most recent twelve month period was not available for review. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 11:25 a.m. to 12:30 p.m. on 03/24/14, smoke detectors hard wired to the fire alarm system were installed on all levels in the corridors, in all areas open to the corridor and in each of 28 resident sleeping rooms.</p> <p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits,</p>		<p>functional testing of firealarm system by contractors and report monthly times 12. The result of theaudit will be reviewed by the Safety Committee Overseen by the ExecutiveDirector. If threshold of 100% is not achieved an action plan will bedeveloped.</p> <p>bywhat date the systemic changes will be completed.</p> <p>April10, 2015</p>		

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	<p>access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure 1 of 5 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 25 residents, staff and visitors if needing to exit the Main Dining Room by the patio.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Director during a tour of the facility from 11:25 a.m. to 12:35 p.m., the Main Dining Room exit which leads to the patio is marked as a facility exit with an exit sign. The patio is enclosed with wood fencing and has a gate for exit discharge to the public way. One six inch in diameter PVC drain pipe for a newly installed basement sump pump was laid on the ground and obstructed the path of egress outside the gate to the public way. Based on interview at the time of observation, the Maintenance Director stated a sump pump had to be installed in the basement within the last year and acknowledged the sump pump drain pipe obstructed the egress path for the Main Dining Room exit at the patio.</p>	K 072	<p>whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; One6inch PVC pipe obstructing egress scheduled to be removed by contractor onApril 16, 2015. howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken;</p> <p>All residents, Staff and Visitorshave the potential to be affected by this deficient practice. One 6inch PVCpipe obstructing egress scheduled to be removed by contractor on April 16, 2015.</p> <p>whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur;</p> <p>One6 inch PVC pipe to be removed April 16, 2015. Maintenance Director will monitorall mean of egress to ensure egress is free from impediments. howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place;and</p> <p>- MaintenanceDirector will complete the Continuous Quality</p>	04/10/2015

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	3.1-19(b)		Improvement audit tool for means of egress is free from impediments weekly times 4 then monthly times 6. The result of the audit will be reviewed by the Safety Committee Overseen by the Executive Director. If threshold of 100% is not achieved an action plan will be developed. — by what date the systemic changes will be completed. April 10, 2015		