

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155815	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/16/2016
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NAME OF PROVIDER OR SUPPLIER CLEARVISTA LAKE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256
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K 0000 Bldg. 01	<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: 05/16/16</p> <p>Facility Number: 013019 Provider Number: 155815 AIM Number: 201251520</p> <p>At this Life Safety Code survey, Clearvista Lake Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility, located on the first floor of a two story building was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 70 and had a census of 55 at</p>	K 0000		

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 0038 SS=E Bldg. 01	<p>the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review on 05/20/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 exit doors with electromagnetic locks unlocked while the fire alarm system was activated. LSC 7.2.1.6.2(e) requires doors with special locking arrangements such as electromagnetic locks shall automatically unlock upon actuation of an approved fire alarm system and remain unlock until the system is reset. This deficient practice could affect at least 5 residents in Therapy as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 05/16/16 during a fire alarm test at 2:47 p.m. with the Maintenance Supervisor, the electromagnetic lock on the Therapy exit door leading to the outside did not unlock upon actuation of the fire alarm</p>	K 0038	<p>K038 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice. No residents, visitors, or staff were effected by the alleged deficiency. Identification of other residents having potential to be effected by the alleged deficient practice: All potential residents, visitors, or staff had the potential to be effected by the alleged deficient practice. Measures put into place and systemic changes made to ensure that the alleged deficient practice does not reoccur: Facility will have electormagnetic lock replaced immediately. Facility Director of Plant Operations/Designee will assure all electormagnetic locks are functioning.</p>	06/15/2016

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K 0050 SS=F Bldg. 01	<p>preventing residents from exiting the Therapy unit. Based on interview on 05/16/16 concurrent with the observation, it was acknowledged by the Maintenance Supervisor, the exit door would not unlock when the fire alarm was activated.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills on each shift for 2 of 4 quarters for 2015. This deficient practice affects all residents in the facility as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports on 05/16/16 at 2:55 p.m. with the Maintenance Supervisor the third shift of</p>	K 0050	<p>K050 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: 1. No Residents, visitors, or staff were effected by the alleged deficiency. 2. No Residents, visitors or staff were effected by the deficiency. Identification of other residents having the potential to be effected by the alleged deficient practice: 1. Per regulation, Director of Plant Operations will successfully complete one fire drill per shift</p>	06/15/2016

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K 0072 SS=E Bldg. 01	<p>the second and fourth quarter of 2015 was not conducted.</p> <p>Based on interview on 05/16/16 during the Fire Drill Report review with the Maintenance Supervisor it was acknowledged there was no other documentation available for review to verify these shifts for the second and fourth quarters of 2015 had been done.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be 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 shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use for 1 of 10 exits. This deficient practice could affect 20 residents, as well as visitors and staff exiting the building from the the Service hall exit.</p> <p>Findings include:</p> <p>Based on observation on 5/16/16 at 2:30</p>	K 0072	<p>perquarter and be abl to provide documentation of such upon request. 1.Facility Director/Designee will monitor the completion of fire drills perregulation. One per shift per quarter. Auditing of the drills will be conductedmonthly times 6 months. Facility Director will sign the fire log after completion of each fire drill.</p> <p>K072 Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice: No residents, visitors, or staff were effected by the alleged deficiency. Identification of other having the potential to be effectedby the alleged deficient practice: No other residents had the potential to be effected by the alleged . Measures put into place and systemic changes made to ensure that the alleged deficient practice does not reoccur: Director of Plant Operations</p>	06/15/2016

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	<p>p.m. with the Maintenance Supervisor, the Service hall is marked as a facility exit and was used to store two Dinex food warmer carts, a broom cart, a buffet table and a metal food storage rack which failed to ensure the means of egress in the Service hall was continuously maintained free of all obstructions or impediments to full instant use. Based on interview at the time of observation with the Maintenance Supervisor, it was acknowledged the Service hall is regularly used as storage of the aforementioned items when not in use.</p> <p>3.1-19(b)</p>		<p>removed all Equipment from the corridor. Per Life Safety Code, the facility will not store items in corridors labeled as exits from the building. How the corrective measures will be monitored to ensure that the alleged deficient practice does not occur: The Director of Plant Operations/Designee will conduct facility rounds daily to ensure that no equipment us stored in corridors marked as exits from the facility. Rounds will be conducted daily times 4 weeks and then weekly times 2 months. Results willbe reported to QA monthly. See attachment D for audit tool.</p>		