

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155521	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/08/2012
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NAME OF PROVIDER OR SUPPLIER  ALEXANDRIA CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1912 S PARK AVE ALEXANDRIA, IN 46001
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K0000	<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: 02/08/12</p> <p>Facility Number: 000518 Provider Number: 155521 AIM Number: 100266670</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Alexandria Care Center 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 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors with no smoke detectors in the resident rooms. The facility has a capacity of 70</p>	K0000	<p>Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</p>	
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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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	<p>and had a census of 62 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/15/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
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K0025 SS=E	<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>Based on observation and interview, the facility failed to ensure 1 of 5 smoke barrier walls was protected to maintain the one half hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire be protected, so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 22 residents on 300 hall as well as visitors and staff if smoke from a fire were to infiltrate the protective barrier wall.</p> <p>Findings include:</p> <p>Based on observations on 02/08/12 at 2:50 p.m. with the Maintenance Supervisor, the 300 hall smoke barrier</p>	K0025	<p>K 0025 Plan of correction effects 22 residents on the Memory Care Unit including visitors and staff.</p> <p>1. The maintenance supervisor sealed the 1" gap around the sprinkler pipe with fire caulk. 2. Administrator re-educated the maintenance staff on the importance of maintaining intact smoke barriers by assuring all areas are completely resealed after any work is completed. 3. Maintenance Supervisor will monitor the integrity of all smoke barriers throughout the facility during their daily rounds. 4. Administrator will monitor the work progress and completion during environmental rounds weekly and review through our Quality Assurance Program.</p>	02/08/2012			

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	wall had a four inch diameter sprinkler pipe penetrating the smoke wall with a one inch gap around the pipe which was not firestopped or sealed with a fire rated material. Based on interview on 02/08/12 at 2:55 p.m. with the Maintenance Supervisor, it was acknowledged the 300 hall smoke barrier wall had an unprotected opening which was not sealed with a fire rated material.  3.1-19(b)			
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K0029 SS=E	<p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 6 doors leading to hazardous areas such as laundry rooms and kitchens were provided with self closing and latching devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 4 residents observed on center hall next to laundry and 29 residents on 100 hall which is adjacent to the kitchen as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 02/08/12 during the tour between 12:27 p.m. and 2:00 p.m. with the Maintenance Supervisor, the laundry room door was not provided with a door closer. Furthermore, the kitchen door was not provided with a door latching device. Based on interview on 02/08/12 concurrent with the observations with the Maintenance</p>	K0029	<p>K 0029 Plan of Correction affects 29 residents that are on 100 hall as well as visitors and staff. 1. The Maintenance staff attached self closing device to to the laundry door and the kitchen door as well as a latching device to the kitchen door. 2. Administrator re-educate the maintenance staff on the importance of assuring all harardous areas are protected by a self closing door with latching system. 3. Maintenance Supervisor will monitor all hazardous areas throughout the building daily during their preventative maintenance rounds. 4. Administrator will monitor areas weekly during environmental rounds and review through Quality Assurance.</p>	02/09/2012			

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	<p>Supervisor, it was acknowledged the aforementioned doors leading into the laundry room and kitchen were not equipped with either a door closing device or a latching device to keep the doors closed.</p> <p>3.1-19(b)</p>			

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K0064 SS=E	<p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 11 portable ABC class fire extinguisher pressure gauge readings was in the acceptable range. NFPA 10, Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect 5 residents on center hall next to laundry as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 02/08/12 at 1:45 p.m. with the Maintenance Supervisor, the gauge on the ABC class portable fire extinguisher located in the corridor on center hall next to the laundry showed the extinguisher was overcharged. Based on interview on 02/08/12 at 1:46 p.m. with the Maintenance Supervisor, it was acknowledged the gauge reading was not in the normal operating range and did not know if it would affect the operation of the fire extinguisher.</p>	K0064	<p>Plan of Correction affects all residents on center hall next to laundry as well as all visitors and guests. 1. Maintenance Supervisor sent extinguishers out to Elwood Fire for correction. Replacement extinguishers guage within normal operating range. 2. Administrator re-educated the maintenance staff on the importance of all extinguishers being maintained within normal operating range. 3. Maintenance Supervisor will evaluate extinguishers daily during preventative maintenance rounds x 30 days then weekly x 30 days and monthly thereafter. 4. Administrator will monitor work progress and completion during environmental rounds weekly and review through Quality Assurance Program at least quarterly.</p>	02/20/2012			

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	3.1-19(b)			
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K0066 SS=E	<p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, record review and interview; the facility failed to ensure cigarette butts were deposited into a noncombustible container provided for 1 of 1 areas where smoking was permitted and failed to ensure a metal container with a self closing lid was provided inside the smoke hut. This deficient practice could affect 3 staff observed in the smoke hut as well as visitors and residents.</p> <p>Findings include:</p> <p>Based on observation on 02/08/12 at 2:15 p.m. with the Maintenance Supervisor, a</p>	K0066	K 0066 Plan of Correction affects one resident as well as visitors and staff. 1. Sign was placed on the self closing metal container within the smoking shed that it was to be used for cigarette butts only. A second trash can was placed within the area for paper materials. 2. Administrator re-educated the all staff that the self closing metal container is not to be used for paper products. 3. Maintenance Supervisor will monitor smoking area for compliance daily during preventative maintenance rounds. 4. Administrator will monitor process and completion weekly during environmental	02/20/2012			

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	<p>plastic thirty gallon trash container used for the disposal of paper goods in the smoking hut just outside the south kitchen exit was also used for the disposal of twelve cigarette butts. Based on review of the smoking policy on 02/08/12 at 3:45 p.m. with the Maintenance Supervisor, the smoking policy did address the proper disposal of extinguished cigarette butts. Based on interview on 02/08/12 at 2:22 p.m. with the Maintenance Supervisor, it was acknowledged the facility's employees disposed of cigarette butts into an unapproved plastic container with paper goods, or on the ground.</p> <p>3.1-19(b)</p>		<p>rounds and review through Quality Assurance program at least quarterly.</p>		

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K0070 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to provide documentation for the use of 1 of 1 portable heating units used in nonsleeping staff areas. This deficient practice could affect 3 staff observed in the smoke hut just outside the kitchen south exit as well as visitors and residents.</p> <p>Findings include:</p> <p>Based on observation on 02/08/12 at 2:15 p.m. with the Maintenance Supervisor, the smoke hut contained one portable space heater which was operating at the time, but documentation was not available to verify the heating elements did not exceed two hundred and twelve degrees F. Based on interview on 02/08/12 at 2:17 p.m. with the Maintenance Supervisor, it was acknowledged the information for the portable heating unit was not available for review to verify the portable heating units did not exceed two hundred and twelve degrees F, and the facility did not have a portable heating unit policy.</p> <p>3.1-19(b)</p>	K0070	K 070Plan of Correction affects 1 resident as well as staff and visitors.1. Maintenance Supervisor purchased infrared thermometer and is documenting the temperature of the portable heater weekly on Wednesdays. Temperature is being documented well below the 212 degree maximum. See attachment "A". Policy for heater written by administrator, reviewed and approved by P&P committee. See attachment "B".2. Administrator re-educated the Maintenance staff on the importance of assuring the heating elements do not exceed 212 degrees.3. Maintenance Supervisor will monitor portable heater weekly during preventative maintenance rounds to assure temperature falls within acceptable range.4. Administrator will monitor documentation weekly during environmental rounds weekly and review through Quality Assurance at least quarterly.	02/20/2012			

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K0130 SS=E	<p><b>OTHER LSC DEFICIENCY NOT ON 2786</b></p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 nonflammable gas cylinders was properly chained or supported in a cylinder stand or cart while in storage. LSC 2.1.1 references NFPA 99, Health Care Facilities. NFPA 99, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 1 resident in the Activities room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 02/08/12 at 1:20 p.m. with the Maintenance Supervisor, the helium cylinder located in the Activities room closet was free standing without being chained or supported in a cylinder stand or cart. Based on interview on 02/08/12 at 1:22 p.m. with the Maintenance Supervisor, it was acknowledged the helium cylinder should have been in a rack or properly secured with the chain provided.</p> <p>3.1-19(b)</p>	K0130	<p>K 130 Plan of Correction affects any resident that would visit the activity room as well as visitors and staff. 1. Maintenance immediately looped the attached chain around the cylinder of helium gas located in the locked closet in the Activity Room. 2. Both Maintenance and Activities staff were educated as to the importance of assuring the cylinder is resecured with chain after each refill. 3. Maintenance Supervisor will monitor the helium tank daily during preventative maintenance rounds x 30 days, then weekly x 30 days, then monthly thereafter. 4. Administrator will monitor documentation and compliance during environmental rounds weekly and review through quality Assurance at least quarterly.</p>	02/20/2012	

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K0143 SS=E	<p>Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transfer occurs had continuously working, electrically powered mechanical ventilation. This deficient practice could affect 6 residents observed on center hall next to therapy as well as visitors and staff in the area.</p> <p>Findings include:</p> <p>Based on observation on 02/08/12 at 2:46 p.m. with the Maintenance Supervisor and Administrator, the oxygen storage room on center hall west used to store and transfer oxygen was provided with electrically powered mechanical ventilation, but was turned off. The light and the mechanical vent were on the same</p>	K0143	<p>K 0143This Plan of Correction affects all residents that utilize the center hall as well as visitors and staff. 1. Ventilation fan was immediately turned on per the wall switch by the Administrator. Maintenance Supervisor attached a locked box over the off/on toggle switch to prevent staff from turning off ventilation fan with light.2. Administrator re-educated the maintenance staff on the importance of assuring that the oxygen storage/transfer closet is well ventilated at all times.3. Maintenance Supervisor will monitor the oxygen storage/transfer closet daily during preventative maintenance rounds x 30 days then weekly thereafter.4. Administrator will monitor work completion during environmental rounds weekly and review</p>	02/20/2012
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	<p>switch. Based on interview on 02/08/12 at 2:50 p.m. it was acknowledged by the the Maintenance Supervisor and Administrator this room was used to transfer oxygen and though it had an electrically powered mechanical vent, it could be turned off with the light switch and was off at the time of inspection.</p> <p>3.1-19(b)</p>		through Quality Assurance program at least quarterly.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155521		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2012	
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K0147 SS=E	<p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 electrical wires observed protruding from an electrical junction box on 300 hall were confined in a junction box with a cover. NFPA 70, National Electrical Code, 1999 Edition, Article 370-28(c) requires exposed electrical wires be confined within a junction box with a cover compatible with the box. This deficient practice could affect 22 residents on 300 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 02/08/12 at 3:25 p.m. with the Maintenance Supervisor, three electrical wires with wire nuts were jutting out of the electrical junction box next to the smoke wall on 300 hall without having a cover over the box.</p> <p>Based on interview on 02/08/12 at 3:27 p.m. with the Maintenance Supervisor, it was acknowledged the electrical wires jutting out of the junction box were not confined within by a cover. .</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1</p>	K0147	<p>K 0147 Plan of Correction affects 22 residents as well as staff and visitors. 1. Maintenance Supervisor immediately covered the electrical box with an appropriate face plate covering the exposed wires. 2. Administrator reeducated the maintenance staff on the importance of assuring that exposed electrical wiring be confined within a junction box. 3. Maintenance Supervisor will monitor electrical outlet to assure there are no exposed wires daily during preventative maintenance rounds. 4. Administrator will monitor work progress and completion weekly during environmental rounds x 30 days then monthly and review through Quality Assurance Program at least quarterly.</p>	02/20/2012			

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	<p>extension cords including powerstrips, nonfused extension cords and/or multiplug adapters were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 28 residents on 200 wing center as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 02/08/12 at 2:30 p.m. with the Maintenance Supervisor, an extension cord was used to plug into a portable heater in the smoke hut which is separate from the facility just outside the kitchen south exit. Based on interview on 02/08/12 at 2:32 p.m., it was acknowledged by the Maintenance Supervisor an extension cord was used to provide electrical power to an electric portable heater in the smoke hut.</p> <p>3.1-19(b)</p>						