

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155717	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/31/2013
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NAME OF PROVIDER OR SUPPLIER  ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN 46222
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K010000	<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: 10/31/13</p> <p>Facility Number: 000376 Provider Number: 155717 AIM Number: 100275510</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, the Alpha Home Association of Greater Indianapolis, Inc. 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 fully sprinklered except for the exterior canopy at the receiving area exit for the 100 Hall. The facility has a fire alarm system with smoke detection in the corridors and in all</p>	K010000		
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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>areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 86 and had a census of 37 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered except for the exterior canopy at the receiving area exit for the 100 Hall. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/06/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 3 sets of smoke barrier doors would close to form a smoke resistant barrier. LSC 19.3.7.6 requires doors in smoke barriers shall comply with Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 28 residents, staff and visitors in vicinity of the smoke barrier doors in the 100 Hall if smoke was allowed to move from one smoke compartment to another.</p> <p>Findings include:</p> <p>Based on observation with the Housekeeping Manager during a tour of the facility from 12:25 p.m. to 2:45 p.m. on 10/31/13, the set of smoke barrier doors in the 100 Hall corridor by Room</p>	K010027	<p>K 027 NFPA 101 Life Safety Code Standard 1. Corrective Action Taken Related to this Finding: It is the policy of the Alpha Home to have a 20 minute fire protection rating on the wood core solid bonded doors, ensure doors are closing properly by only allowing the minimum clearance necessary for proper operation 1/8 inch. The contractors have come out to the facility and repaired the doors on the 100 hallway to ensure the east and west doors are closing in the smoke barrier frame. The contractors made the adjustment on the east door latching mechanism. 2. Other Residents with Potential to be affected by this finding will be identified by: Documented regular logs with the fire barrier doors closing and latching in the door frame. Potentially all the residents can be affected by this finding, however at the time of this finding no additional residents were identified. The facility will continue</p>	11/30/2013	

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	<p>101 which are held open by a magnetic holding device and swing in the opposite direction failed to fully close leaving a one inch gap between the set of doors when the door set was manually closed five times. The latching mechanism on the bottom of the east door dragged on the floor and prevented the door from fully closing. In addition, the aforementioned smoke barrier door set failed to fully closing leaving a a one inch gap between the set of doors when the fire alarm system was activated at 2:30 p.m. Based on interview at the time of observation, the Housekeeping Manager acknowledged the aforementioned set of smoke barrier doors failed to fully close leaving a one inch gap between the east and west door.</p> <p>3.1-19(b)</p>		<p>to monitor the smoke doors on all three of the smoke barrier door. 3. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: Contractors to replace hardware on the smoke barrier doors when needing replacement, Additional license inspection for routine monitoring of the doors closing within the 1/8inch barrier range. IV. Corrective Actions will be monitored to Ensure Compliance by: Review and recommendation of the inspection reports presented to the Quality Assurance completely weekly for the next three months for complince. 11/30/13</p>	

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K010048 SS=B	<p>NFPA 101 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. 19.7.1.1 Based on record review, observation and interview; the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice affects 5 staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on review of "Fire Safety &amp; Disaster Preparedness" documentation during record review with the Housekeeping Manager from 9:20 a.m. to 11:20 a.m. on 10/31/13, the facility's written fire safety plan did not address the use of ABC type fire extinguishers and the K-class fire extinguisher located in the</p>	K010048	<p>K 048 NFPA 101 Life Safety Code Standard 1. Corrective Action Taken Related to this Finding: The written fire safety policy is posted in the kitchen which states the use of ABC type fire extinguisher for the various types of fires. Additionally, in the kitchen area with a fire in this area the hood suppression system is activated prior to the use of an ABC type fire extinguisher or K class fire extinguisher. 2. Other Residents with the potential to be affected by this finding will be identified by: The posting of the kitchen policy, explaining the use of fire extinguisher for use with the hood. Potentially all the residents can be affected by this finding, however at the time of this finding no additional residents were identified. 3. Measures and Systemic Changes put into place to assure Deficit Practices do not recur are as Follows: In-service staff on the various types of fire extinguishers, explanation with the types of fire extinguisher to use with a grease fire and the activation and use of the hood suppression system, 4. Corrective Actions will be monitored to Ensure Compliance by: 11/31/13</p>	11/30/2013			

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	<p>kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Housekeeping Manager acknowledged the written fire safety plan for the facility did not include the policy to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K-class fire extinguisher. Based on observation with the Housekeeping Manager during a tour of the facility from 12:25 p.m. to 2:45 p.m. on 10/31/13, one K class and one ABC type fire extinguisher were located in the kitchen.</p> <p>3.1-19(b)</p>				

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K010050 SS=F	<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>1. 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.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Housekeeping Manager during record review from 9:20 a.m. to 11:20 a.m. on 10/31/13, documentation of a fire drill conducted on the third shift for the third quarter of 2013 was not available for review. Based on interview at the time of record review, the Housekeeping Manager acknowledged documentation of a fire drill conducted on the third shift for the third quarter of 2013 was not available for review.</p> <p>3.1-19(b)</p>	K010050	<p>K 050 NFPA 101 Life Safety Code Standard Corrective Action Taken Related to this Finding: 1. The Alpha Home has downloaded the form and information from the ISDPH/Gov. website. No fire drill to be conducted without first notifying the monitoring company before each drill and documentation the specific time of the call. Unannounced drill results to be reviewed by the interdisciplinary team and presented to quality assurance.</p> <p>2. Other Residents with Potential to be affected by this finding will be identified by: Unannounced drills time documentation supplied by the monitoring company with verification of the call for do not sound the alarm time. Fire drills with coded announcements between the hours of 9pm and 6am. Maintenance Director presented schedule of one year advance notification of the quarterly drills. Highlighted quarterly drills non alarm use.</p> <p>3. Measures and Systemic</p>	11/30/2013

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	<p>2. Based on record review and interview, the facility failed to activate the fire alarm system for fire drills conducted between 6:00 a.m. and 9:00 p.m. on the second shift for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Housekeeping Manager during record review from 9:20 a.m. to 11:20 a.m. on 10/31/13, documentation for the second shift fire drill conducted at 8:00 p.m. on 09/15/13 stated "Coded Announcement" in response to "Fire Alarm Activation Method." The aforementioned documentation stated "8:15 p.m." in response to "Monitoring company received signal." Based on interview at the time of record review, the Housekeeping Manager stated the fire alarm system was not activated for the 09/15/13 second shift fire drill at 8:00</p>		<p>Changes put into Place to Assure Deficit Practices do not recur are as Follows: Validation time with the fire alarm company with the announcement of non-alarm sounding. In-service with staff on the various types of fire extinguishers, with the types of fire especially extinguisher to use with a grease fire. 4. Corrective Actions will be monitored to Ensure Compliance by: 11/31/13</p>				

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	<p>p.m., the documentation stating the monitoring company received a signal in response to fire alarm system activation was incorrect and acknowledged documentation for 1 of 4 second shift fire drills conducted before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to accurately document fire drills conducted on the third shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Housekeeping Manager during record review from 9:20 a.m. to 11:20 a.m. on 10/31/13, documentation for the third shift fire drill conducted on 04/10/13 stated the "third shift" fire drill was conducted at "3:30 p.m." Based on interview at the time of record review, the Housekeeping Manager stated the third shift for the facility is from 12:00 a.m. to 7:00 a.m., the fire drill was actually performed at 3:35 a.m. and acknowledged the 04/10/13 third shift fire drill documentation did not</p>			
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	<p>record the correct time of day the fire drill was conducted.</p> <p>3.1-19(b)</p>			

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K010052 SS=F	<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</p> <p>1. Based on record review and interview, the facility failed to document annual testing of the facility fire alarm system. NFPA 72, 7-3.2 refers to fire alarm component testing frequencies in Table 7-3.2 which requires an annual fire alarm system test. 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 in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Housekeeping Manager from 9:20 a.m. to 11:20 a.m. on 10/31/13, documentation of a fire alarm system inspection within the last twelve months was not available for review. Based on interview at the time of record review, the Housekeeping Manager acknowledged documentation of a fire alarm system inspection within the last twelve months was not available for review.</p>	K010052	<p>K 052 NFPA 101 Life Safety Code Standard Corrective Action Taken Related to this Finding Safe care contractors have supplied the sensitivity testing for the Alpha Home. The contractor will continue to provide the testing on the regular schedule basis and immediately provide the results of the testing to the Alpha Home. The contractor to provide written proposals and guarantee any scheduled work. Recommendation from testing to be completed by safe care also. 2. Other Residents with Potential to be affected by this finding will be identified by: Potentially all the residents can be affected by this finding, however at the time of this finding no additional residents were identified. 3. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: Regular scheduled sensitivity test every other year. Follow up contractor repair with calibration per the testing specifications. 4. Corrective Actions will be monitored to Ensure Compliance by: 11/31/13</p>	11/30/2013			

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	<p>3-1.19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure all smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in 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 any of the following methods:</p> <p>(1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for</p>			
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	<p>the purpose</p> <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</p> <p>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Housekeeping Manager from 9:20 a.m. to 11:20 a.m. on 10/31/13, smoke detector sensitivity testing documentation for the most recent two year period was not available for review. Based on interview at the time of record review, the Housekeeping Manager acknowledged documentation of smoke detector sensitivity testing in the last two years was not available for review. Based on observations with the Housekeeping Manager during a tour of the facility from 12:25 p.m. to 2:45 p.m. on 10/31/13, smoke detectors hard wired to the fire alarm system were observed installed in the corridors and in each of the 43</p>			

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	resident sleeping rooms.  3.1-19(b)			

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NAME OF PROVIDER OR SUPPLIER  ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN 46222
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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 2 combustible exterior canopies wider than 4 feet. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect 28 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Housekeeping Manager during a tour of the facility from 12:25 p.m. to 2:45 p.m. on 10/31/13, the exterior canopy at the receiving area exit for the 100 Hall extended four and one half feet from the building, was of wood construction and</p>	K010056	<p>K 056 NFPA 101 Life Safety Code Standard 1. Corrective Action Taken Related to this Finding: The policy of the Alpha Home is to provide sprinkler coverage for exterior canopies that measure wider than four feet. The Alpha Home has received written proposals to install sprinkler heads in the area that exceed more than the four feet of the building. 2. Other Residents with Potential to be affected by this finding will be identified by: There were no identifiable residents affected by this finding potentially all the residents can be affected by this finding, however at the time of this finding no additional residents were identified. 3. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: All exterior canopies of the Alpha Home have</p>	11/30/2013

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	<p>was not provided with automatic sprinklers. Based on interview at the time of observation, the Housekeeping Manager acknowledged the aforementioned canopy extended more than four feet from the building, was of combustible construction and was not provided with automatic sprinklers.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>been measure to ensure that none exceed the four feet. Areas that measure more than the four feet will have additional sprinkler head installed. 4. Corrective Actions will be monitored to Ensure Compliance by: Installation of the sprinkler head on any canopy that exceed more than the four feet, on the Alpha Home exterior. Completion of installation by 11/31/13</p>	

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K010062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review, observation and interview; the facility failed to ensure quarterly sprinkler inspections were conducted for the sprinkler system for 1 of 4 calendar quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code to be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of SafeCare "Report of Inspection" documentation dated 08/16/13, 05/22/13 and 11/16/12 with the Housekeeping Manager during record review from 9:20 a.m. to 11:20 a.m. on</p>	K010062		11/30/2013			

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	<p>10/31/13, the first quarter (January, February, March) 2013 sprinkler system inspection report was not available for review. Based on observations with the Housekeeping Manager during a tour of the facility from 12:25 p.m. to 2:45 p.m. on 10/31/13, calendar quarter sprinkler inspection tags affixed to the sprinkler system riser in the main mechanical room did not document a first quarter 2013 inspection. Based on interview at the time of record review and of the observations, the Housekeeping Manager acknowledged the first quarter 2013 sprinkler system inspection report was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 1 of over 100 sprinklers in the facility which had paint on them. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 5 kitchen staff and visitors.</p>						

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	<p>Findings include:</p> <p>Based on observation with the Housekeeping Manager during a tour of the facility from 12:25 p.m. to 2:45 p.m. on 10/31/13, the automatic sprinkler located on the ceiling in the kitchen bathroom was entirely covered with yellow paint. Based on interview at the time of observation, the Housekeeping Manager acknowledged the aforementioned automatic sprinkler was entirely covered with yellow paint.</p> <p>3.1-19(b)</p>						

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			Requested Addendum For Original POC	



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			<p>corrective measures have been taken to replace the sprinkler head in the</p> <p>kitchen bathroom?</p> <p>1 The replacement sprinkler head has been received and</p> <p>installed in the kitchen bathroom.</p>	

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			<p>This was completed by Safe care contractors.</p> <p>2. What measures and</p> <p>systemic changes were put into place to assure deficient practice does not</p>		

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			<p>recur?</p> <p>There shall be no painting of the sprinkler heads in the</p> <p>ceiling for the Alpha Home. All painting purchase orders must be reviewed, before</p> <p>any area the area painted. Any area painted reviewed by Maintenance Director</p>	

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			<p>and Administrator for replacement heads if necessary. Safe care consultants</p> <p>will be responsible for the removing and replacing of the sprinkler heads and</p> <p>ensuring the heads are fully operational.</p> <p>The Maintenance Director is responsible for ensuring the</p>	

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			<p>painting is completed correctly. The Administrator is responsible for ensuring</p> <p>the sprinklers are replaced and functioning properly.</p> <p>K 062 NFPA 101 Life Safety Code Standard 1. Corrective Action Taken Related to this Finding: Safe care has completed the sprinkler inspection, moving forward the facility will maintain the completed sprinkler reports in the administrator's office as well as in the log book in the Maintenance office. The Maintenance Director has setup a log book for the scheduling of the sprinkler test each quarter. 2. Other Residents with Potential to be affected by this finding will be identified by: Potentially all the residents can be affected by this finding, however at the time of this finding no additional residents were</p>	

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			identified. 3. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: The quarterly sprinkler schedule, for each quarterly test completed. Record keeping with the completed test safeguarded in the administrator's office as well as in the Maintenance Director's office. 4. Corrective Actions will be monitored to Ensure Compliance by: Dual copies of the test in the administrator office as well as in the Maintenance Director's office. Quarterly log to ensure each test is completed timely each quarter. 11/31/13		

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K010069 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect five staff and visitors in the kitchen.</p> <p>Findings include:</p>	K010069	<p>K 69 NFPA 101 Life Safety Code Standard Corrective Action Taken Related to this Finding: The Alpha Home has entered into a sign agreement with a certified contractor to conduct the kitchen inspections semiannually. This contractor will conduct the first inspection within the next thirty days. Any cleaning to be completed by the licensed certified contractor with the report submitted to the administrator and the maintenance director. 2. Other Residents with Potential to be affected by this finding will be identified by: Potentially all the residents can be affected by this finding, however at the time of this finding no additional residents were identified. 3. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: Licensed contractor hired. Any cleaning by the licensed certified contractor. Record of the inspection kept in administrator's office as well as in the Maintenance Director Log book. IV. Corrective Actions will be monitored to Ensure Compliance by:11/31/13</p>	11/30/2013			

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	<p>Based on record review with the Housekeeping Manager from 9:20 a.m. to 11:20 a.m. on 10/31/13, documentation of semiannual kitchen exhaust system inspections for the most recent twelve month period was not available for review. "Cleaning Chart for Hood &amp; the Vent" documentation stated the kitchen range hood filters and the exhaust vent were cleaned by facility staff on a monthly basis for the twelve month period of 11/16/12 to 10/16/13. Based on interview with the Housekeeping Manager and with the Administrator during the exit interview at 2:45 p.m., the facility does not utilize a contractor to clean the kitchen hoods, grease removal devices, fans, ducts, and other appurtenances at regular intervals. The Administrator stated a contractor inspects the exhaust hood fan and belts at regular intervals but acknowledged documentation of semiannual inspections for the most recent twelve month period was not available for review.</p> <p>3.1-19(b)</p>				

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K010130 SS=C	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure 4 of 4 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Housekeeping Manager during a tour of the facility from 12:25 p.m. to 2:45 p.m. on 10/31/13, the following natural gas fired water heaters each located in the main mechanical room and rated at 116 gallon capacity had missing Certificate of Inspection documentation from the State of Indiana:</p> <p>a) the service water heater identified as IN311298. b) the service water heater identified as IN311299. c) the service water heater identified as IN311300. d) the service water heater identified as</p>	K010130	<p>K 130 NFPA 101 Life Safety Code Standard Corrective Action Taken Related to this Finding: Water Heater identified as IN311298 certificate produced and copy placed in water heater area. Water Heated identified as 311299 certificate produced and placed in the water heater area. Water heater identified as IN311300 certificated produced and placed in the water heater area. Water heater identified as IN311401 certificate produced and placed in the water heater area. 2. Other Residents with Potential to be affected by this finding will be identified by: Potentially all the residents can be affected by this finding, however at the time of this finding no additional residents were identified. 3. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: One copy to be kept by administrator, one copy in the log book for Maintenance director, one copy with the water heaters and one copy with the insurance company. 4. Ensure Compliance by: 11/30/13</p>	11/30/2013			

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	<p>IN311401.</p> <p>Based on interview at the time of the observations, the Housekeeping Manager stated current Certificate of Inspection documentation is kept in no other location than at the service water heater location and acknowledged the aforementioned service water heaters had missing Certificate of Inspection documentation from the State of Indiana.</p> <p>3.1-19(b)</p>			
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