DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155651	A. BUILDING 01 B. WING	11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEVIEW CENTER OF FRANKLIN	651 SOUTH STATE STREET FRANKLIN, IN 46131

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K 0000 Bldg. 01	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). Survey Date: 11/16/16 Facility Number: 000353 Provider Number: 155651 AIM Number: 100291330 At this Life Safety Code survey, Homeview Center of Franklin was found not in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility consists of two sections: the original building built in 1985 was determined to be of Type V (111) construction was fully sprinklered and the New Wing addition added to the south of the original building in 2005 is of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the	K 0000		

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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	corridor and hard wired smoke detectors in resident sleeping rooms. The facility has a capacity of 115 and had a census of 109 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has one detached building providing facility services which was not sprinklered. Quality Review completed on 11/21/16 - DA			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10			
	Based on observation and interview, the facility failed to ensure 2 of 21 portable fire extinguishers had the date of 6-year maintenance documented on each container in accordance with NFPA 10. LSC 19.3.5.12 states portable fire extinguishers shall be provided in accordance with 9.7.4.1. Section 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, 2010 Edition, Section 7.3.1.1.2 states fire extinguishers shall be internally examined at intervals not	K 0355	This Plan of Correction is the center's allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections prepared and/or executed solely because it is required by the provisions of federal and state law. K355 1.) Immediate action taken for those residents identify: The facility had its annual Allied Safety Service inspection and replacement of fire	11/29/2016

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	exceeding those specified in Table 7.3.1.1.2. Every six years, stored pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable internal examination procedure as detailed in the manufacturer's service manual and this standard. Fire extinguishers that pass the applicable 6-year requirement shall have the maintenance information recorded on a durable weatherproof label that is a minimum size of 2 inches by 3.5 inches. The label shall be affixed to the shell and shall include the month and year the maintenance was performed. The label shall include the initials of the person performing the maintenance and the name of the agency performing the maintenance. A verification of service collar shall be located around the neck of the container indicating the month and year of service and the name of the agency performing the maintenance or recharge. This deficient practice could affect 30 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 2:00 p.m. on 11/16/16, the following was noted: a. the ABC type portable fire extinguisher located at the Station 1 nurse's station		extinguishers and service on 1/7/16. Homeview also called Allied Safety Services and Fire Protection, back out for on 11/17/16 following annual Life Safety inspection. On the Alzheimer's Unit a new ABC Extinguisher was replaced. The paper collar may have come off being the Alzheimer's Unit therefore the entire extinguisher was replaced.2)How the facility identified other residents: All extinguisher were audit and there were no other affected. 3.) Measures put into place/System Changes: The facility maintenance has a monthly protocol to check all fire extinguishers. Maintenance will check for pin being intake, extinguisher in the charge zone and will audit if a collar is needed and intake. It will be the new protocol any extinguisher needed a collar will not be left back on the Alzheimer's Unit where the collar could be removed.4.) How the corrective actions will be monitored: The Allied Safety and Fire Protection will be at Homeview for an annual service 1/2017. If a unit needs a collar we will assure it will not be kept on Station 2(Alzheimer's Unit) Maintenance will have a list of any extinguisher needing a collar so we can track it on the monthly audit. The Kidde , Fire Extinguisher on Station 1 was also replaced with a brand new purchased ABC extinguisher. Station 2 was replaced with a new ABC extinguisher as well.	

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	was manufactured in 2009 and had no 6-year maintenance sticker or maintenance collar affixed to the container. b. the ABC type portable fire extinguisher located in the Station 2 dining room had an affixed sticker indicating 6-year maintenance was performed June 2013 but had no maintenance collar affixed to the neck of the container. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged each of the two portable fire extinguishers did not have 6-year maintenance properly documented on the containers. 3-1.19(b)		5.) Date of Compliance: 11/29/16.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door			

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	and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 58 resident room doors protecting corridor openings would resist the passage of smoke. This deficient practice could affect 15 residents, staff and visitors in the vicinity of Room 322. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 2:00 p.m. on 11/16/16, a three quarter inch gap between the face of the door and the door	K 0363	K363 1.) Immediate actions taken for those residents Identified: Homeview staff audited 100% of resident rooms. No other doors in the facility have a gap that could allow the passage of smoke. 2.) How the facility identified other residents: The facility has a TELS Maintenance system for Audits, work orders and preventative maintenance work.	01/13/2017

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	stop on the handle side of the door was noted in the corridor door to Room 322 when closed and latched. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned gap in between the corridor door to Room 322 and the door stop would not resist the passage of smoke when fully closed and latched. 3-1.19(b)		3.) Measures put into place/Systems changes: On the TELS System maintenance will monthly log door check to assure the door close and have no gaps. 4.) How the corrective actions will be monitored: On 11/29/16 the facility ordered a new door for Room 322. The new door will be a finished door and will be delivered and installed in 6 weeks. Central Indiana Hardware doors have the order and payment. 5.) Date of compliance: 1/13/17	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 3 sets of	K 0374	K374	01/13/2017

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	smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 15 residents in the vicinity of the smoke barrier door set by Room 314. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 2:00 p.m. on 11/16/16, the set of corridor smoke barrier doors by Room 314 had a one inch gap where the doors came together in the closed position near the bottom of the door set. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned corridor smoke barrier door set had a one inch gap between the meeting edges of the door set. 3.1-19(b)		1.) Immediate actions taken for those residents Identified: The Corridor Smoke barrier doors by the room 314 and by the Conference Room. 2.) How the facility identified other residents: After 100% audit no other doors have a gap in the door. 3.) Measures put into place/Systems changes: The Maintenance Supervisor have added to the TELS System monthly Audits. 4.) How the corrective actions will be monitored: On 11/29/16 the facility ordered from Central Indiana Hardware, two new finished doors. The delivering and installation will take 6 weeks. 5.) Date of compliance: Estimate date of completed is expected on 1/13/17. The purchase of the new doors occurred on 11/29/16.	

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K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills 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. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7			
	Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report" documentation with the Maintenance Supervisor during record review from 9:10 a.m. to 11:25 a.m. on 11/16/16,	K 0712	K712- Fire Drills 1.) Immediate Actions taken for those residents identified: I would like to respectfully disagree with regards to the citation of varied fire drills. Homeview conducted 12 fire drills in the past year. Homeview actually had a fire October 2015 at 8:30 pm and our staff saved lives and saved the building. Then in November 2015 a fire drill was conducted 11/27/15 at 3:01 pm, on 2/26/16 a fire drill was conducted at 2:25pm and on 8/31/16 at 7:02pm.	11/30/2016

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	second shift (2:00 p.m. to 10:00 p.m.) fire drills conducted on 11/27/15, 02/26/16 and 05/27/16 were conducted at, respectively, 3:00 p.m., 2:30 p.m. and 3:00 p.m. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned second shift fire drills were not conducted at unexpected times under varying conditions. 3.1-19(b)		The August Fire Drill was 4.5 hours in time variation from previous quarter. According to Homeview Policy and NFPA code I believe we are fully in compliance with this regulation. No residents have been identified as place at harm but more important our staff our fully trained and well equipped to meet an emergency as it could arise. 2.) How the facility identified other residents: Again no residents or facility identified as to any lapse of code or policy. 3.) Measures put into place/systems changes: On November 29th 2016 was our next fire drill was conducted on second shift at 9:30 pm. From November 2016 all fire drills will be separated and varied by 2 hours. Homeview keeps a 12 month fire drill calendar and one drill occurs each quarter on the specific shift. 4.) How the corrective actions will be monitored: The annual calendar will continue to kept. Every supervisor participates in the fire drills. The Maintenance Supervisory is responsible to alert the Administrator of day and time of month and the leaders supervise the monthly fire drill. Our maintenance supervisor and Safety Committee all received the education that the definition and survey protocol of varied times of fire drills is 2-4 hours.	

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			5.) As of 11/30/16 our second shift fire drill at 9:45pm shows our varied time.	