

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155171	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2014
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NAME OF PROVIDER OR SUPPLIER FRANKLIN MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1285 W JEFFERSON ST FRANKLIN, IN 46131
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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: 07/31/14</p> <p>Facility Number: 000087 Provider Number: 155171 AIM Number: 100289890</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code Survey, Franklin Meadows 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 (000) construction and fully sprinklered except for the Therapy Room bathroom closet. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. Battery operated smoke</p>	K010000	<p>To Whom It May Concern:</p> <p>On July 31, 2014 a Life Safety Code Survey was conducted at Franklin Meadows Skilled Nursing Facility. This letter is attached to the plan of correction, which does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.</p> <p>We are respectfully requesting that the attached plan of correction be considered the letter of credible allegation and requesting a desk review, in lieu of a Post Survey review.</p> <p>Thank you very much for your time and consideration.</p> <p>Sincerely,</p> <p>Michael Kalmas</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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K010015 SS=D	<p>detectors are installed in all resident sleeping rooms. The facility has a capacity of 114 and had a census of 90 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered except for the Therapy Room bathroom closet. All areas providing facility services were sprinklered except three detached wooden sheds providing facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/07/14.</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 Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1,</p>		<p>Executive Director</p> <p>Franklin Meadows</p>				

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	<p>19.3.3.2</p> <p>Based on observation and interview, the facility failed to provide documentation of the flame spread rating for interior finish materials installed in 1 of over 75 rooms. This deficient practice could affect 5 staff and visitors in the vicinity of the laundry.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Maintenance Supervisor during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 07/31/14, the following was noted behind the dryers in the laundry:</p> <p>a. an eight feet high by eight feet long section of the wall by the entry door had exposed wood studs on the dryer side of the wall.</p> <p>b. an eight feet long by two feet high section of the wall above the dryers had exposed wood studs on the dryer side of the wall.</p> <p>c. a six feet high by one foot wide by eight inches deep framing for the combustion air intake for the fuel fired dryers consisted of exposed wood studs. Based on interview at the time of observation, the Maintenance Director stated the exposed wood studs had not been treated with a flame retardant material and acknowledged flame spread</p>	K010015	<p>PLAN OF CORRECTION</p> <p>Franklin Meadows</p> <p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Certification Review or Post Certification Review on or after 8/18/14.</p> <p><u>K015</u></p> <p>The facility strives to ensure that interior finish for rooms and spaces not used for corridors or exit ways, has a flame spread rating of Class A, Class B, or Class C fire rating.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by deficient practice?</p> <ul style="list-style-type: none"> · No residents were cited for the alleged practice. · The maintenance director/designee has treated the exposed 	08/18/2014			

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	rating documentation was not available for review for the exposed wood studs in the laundry behind the dryers. 3.1-19(b)		<p>wood studs with a flame retardant material.</p> <ul style="list-style-type: none"> The maintenance director has inspected facility to ensure no other exposed wood is present within the facility. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All occupants in the facility including staff, visitors and residents have potential to be affected. The maintenance director/designee has treated the exposed wood studs with a flame retardant material. <p>What systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> The maintenance director/designee has treated the exposed wood studs with a flame retardant material/film. <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> Maintenance personnel have been educated by ED that all exposed wood needs to have a fire rating and have rating documentation available. 	

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K010046 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 1 of 4 battery powered lights during the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be</p>	K010046	<ul style="list-style-type: none"> · Maintenance personnel will conduct facility inspection to ensure no un-treated exposed wood is present. Preventative Maintenance month sheet will be updated to reflect inspection and signed off by ED Monthly on-going. · Data will be submitted to the CQI Committee for review and follow up to determine if not an action plan will need developed. · Completion Date: 8/18/14 <p>K046</p> <p>The facility strives to ensure that emergency lighting has periodic functional testing completed.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by deficient practice?</p> <ul style="list-style-type: none"> · No residents were cited for the alleged practice. · The maintenance director has tested all emergency lighting per policy with emergency lighting functioning properly. <p>How will you identify other residents</p>	08/18/2014
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	<p>kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect five staff and visitors in the service hall.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Emergency Lights-Test Log for 2013 and 2014" with the Executive Director and Maintenance Supervisor during record review from 9:30 a.m. to 12:10 p.m. on 07/31/14, the following was noted:</p> <p>a. documentation of functional testing for not less than 30 seconds for the service hall battery powered emergency light for January through June 2014 was not available for review.</p> <p>b. documentation of an annual test for the service hall battery powered emergency light for not less than 1 ½ hour duration for the most recent twelve month period was not available for review.</p> <p>Based on interview at the time of record review, the Maintenance Director acknowledged documentation of functional testing for not less than 30 seconds for the service hall battery powered emergency light for the first six months of 2014 and annual testing documentation for the aforementioned battery powered emergency light was not available for review. Based on observations with the Executive Director</p>		<p>having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All occupants in the facility including staff, visitors and residents have potential to be affected. · The maintenance director has tested all emergency lighting per policy with emergency lighting functioning properly. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · The maintenance director has been educated that all emergency lighting be tested per policy each month and annually. · Emergency lighting has been tested for not less than 1 ½ hour has been completed and documented on a preventative maintenance log. <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · The maintenance director/designee will complete testing of all emergency lighting in accordance with policy on a monthly basis. · Emergency lighting will be tested at 30-day intervals for not less than 30 seconds and an annual test of not less than 1 ½ hour will be completed and documented on a preventative 				

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K010056 SS=E	<p>and the Maintenance Supervisor during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 07/31/14, a total of four battery powered emergency lights including the service hall light were located in the facility and each battery powered emergency light operated when their respective test button was pushed.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 ensure a sprinkler was installed in 1 of 1 Therapy Room bathroom closets to provide coverage for all portions of the building. This deficient practice could affect 10 residents, staff and visitors.</p>	K010056	<p>maintenance log.</p> <ul style="list-style-type: none"> The preventative maintenance log will be reviewed and signed off by the ED/designee monthly on-going. Data will be submitted to the CQI Committee for review and follow up to determine if not an action plan will need developed. Completion Date: 8/18/14 <p><u>K056</u></p> <p>The facility strives to ensure that an automatic sprinkler system is installed to provide complete coverage for all portions of the building.</p> <p>What corrective actions will be</p>	08/18/2014

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	<p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Supervisor during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 07/31/14, the bathroom closet in the Therapy Room was not sprinklered. Based on interview at the time of observation, the Executive Director and the Maintenance Supervisor acknowledged the aforementioned closet was not provided with a sprinkler head.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>accomplished for those residents found to have been affected by deficient practice?</p> <ul style="list-style-type: none"> · No residents were cited for the alleged practice. · The maintenance director has removed the closet and the closet has been dry-walled. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All occupants in the facility including staff, visitors and residents have potential to be affected. · The maintenance director has removed the closet and the closet has been dry-walled. · The maintenance director has inspected all closets and every closet has a sprinkler head present. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · The maintenance director has been educated that all closets in the facility must have a sprinkler head by the ED. <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p>		

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K010130 SS=C	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 58 of 58 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include: Based on review of "Battery Operated</p>	K010130	<ul style="list-style-type: none"> · The maintenance director has removed the closet and the closet has been dry-walled. · Maintenance personnel will conduct facility inspection to ensure no closet has been added without a sprinkler. Preventative Maintenance month sheet will be updated to reflect inspection and signed off by ED Monthly on-going. · Data will be submitted to the CQI Committee for review and follow up to determine if not an action plan will need developed. · Completion Date: 8/18/14 <p>K130 The facility strives to ensure that a preventive maintenance program for battery operated smoke detectors is in place. What corrective actions will be accomplished for those residents found to have been affected by deficient practice? · All occupants in the facility including staff, visitors and residents have potential to be affected. · The maintenance director has cleaned all smoke detectors per manufacturer's recommendation. How will you identify other residents having</p>	08/18/2014

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	Smoke Detector Maintenance Log for 2013 and 2014" with the Executive Director and Maintenance Supervisor during record review from 9:30 a.m. to 12:10 p.m. on 07/31/14, resident sleeping room battery operated smoke detector cleaning documentation within the most recent twelve month period stated cleaning was performed semiannually on 01/02/14 and 07/11/14. In addition, review of First Alert Model SA340 battery operated smoke detector "Users Manual" stated to "clean the smoke alarm at least once a month." Based on observations with the Executive Director and the Maintenance Supervisor during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 07/31/14, First Alert Model SA340 battery operated smoke detectors are installed in each of 58 resident sleeping rooms. Manufacturer's specifications affixed to the smoke detectors stated to clean once per month. Based on interview at the time of record review and of the observations, the Executive Director and the Maintenance Supervisor stated cleaning is performed semiannually and acknowledged documentation of battery operated smoke detector cleaning for ten of the most recent twelve months was not available for review. 3.1-19(a)		the potential to be affected by the same deficient practice and what corrective action will be taken? · All occupants in the facility including staff, visitors and residents have potential to be affected. · The maintenance director has cleaned all smoke detectors per manufacturer's recommendation. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · The maintenance director has been educated that all smoke detectors be cleaned per manufacturer's recommendations or at a minimum of semi-annually, whichever is more frequent. · The maintenance director/designee will complete cleaning of all smoke detectors in accordance with manufacturer's recommendations or at a minimum of semi-annually, whichever is more frequent. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The maintenance director/designee will complete cleaning of all smoke detectors in accordance with manufacturer's recommendations or per policy, whichever is more frequent. · Smoke detector cleaning will be completed and documented on a preventative maintenance log per				

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			<p>manufacturer's recommendations or per policy, whichever is more frequent. · The preventative maintenance log will be reviewed and signed off by the ED/designee monthly on-going.</p> <p>· Data will be submitted to the CQI Committee for review and follow up to determine if not an action plan will need developed.</p> <p>· Completion Date: 8/18/14</p>		