

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/02/2014
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NAME OF PROVIDER OR SUPPLIER MADISON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVE INDIANAPOLIS, IN 46227
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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: 12/02/14</p> <p>Facility Number: 012225 Provider Number: 155780 AIM Number: 200983560</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Madison Health 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 III (200) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all</p>	K010000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings We reserve the right to contest the findings as part of any proceedings and submit these responses pursuant to our regulatory obligations The facility request that the plan of corrections be considered for compliance effective December 19, 2014 We respectfully request a paper review and will provide any additional information necessary as requested to confirm that all areas of the plan of corrections have been completed	

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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K010029 SS=E	<p>resident sleeping rooms. The facility has a capacity of 130 and had a census of 88 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached storage shed.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/05/14.</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 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>1. Based on observation and interview, the facility failed to ensure 2 of 18 hazardous areas such as combustible storage rooms greater than 50 square feet</p>	K010029	K029 The facility has in place policies and procedures to identify hazardous areas 1) The combustibles in 213+214 are removed 2) All 14 staff and	12/19/2014

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	<p>in size were separated from other areas by self closing doors. Doors to hazardous areas are self closing or close automatically upon activation of the fire alarm system. This deficient practice could affect 14 staff and visitors in the 200 Hall.</p> <p>Findings include:</p> <p>Based on observations with the Director of Housekeeping and Laundry during a tour of the facility from 11:40 a.m. to 2:50 p.m. on 12/02/14, Room 213 and Room 214 each measured in excess of 180 square feet and were being used to store combustible boxes, mattresses, wheelchairs and furniture. The corridor door to each room was not equipped with a self closing device. Based on interview at the time of the observations, the Director of Housekeeping and Laundry acknowledged the aforementioned hazardous areas were not separated from other spaces by a self closing corridor door.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 18 hazardous areas such as fuel fired heater rooms were separated from other spaces by smoke resistant partitions and doors.</p>		<p>visitors have potential to be affected Maintenance Director will evaluate the facility on daily rounds to ensure storage rooms meet K029 Standards Maintenance Director will do a daily walk about weekly to meet K029 standards Audits completed by Maintenance director will be the subject of ongoing review by the QAPI committee Anything less than 100% compliance will require an action plan for correction KO29 The Facility has in place policies and procedures to ensure hazardous areas are separated from other spaces by smoke resistant partitions and doors 1) One inch in diameter hole was patched 2) All staff residents have the potential to be affected 3) Maintenance will monitor hazardous areas to ensure separation from other spaces by smoke resistant partitions 4) Monitoring results will be reported to the QAPI Committee on a monthly bases KO46 the battery operated emergency lights is inspec</p>	

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K010046 SS=C	<p>This deficient practice could affect four staff and visitors in the vicinity of the service corridor Mechanical Room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Housekeeping and Laundry during a tour of the facility from 11:40 a.m. to 2:50 p.m. on 12/02/14, a one inch in diameter hole was noted next to an electrical fixture in the north wall of the service corridor which did not ensure the room was separated from other spaces by smoke resistant partitions. The aforementioned room contained two natural gas fired water heaters. Based on interview at the time of observation, the Director of Housekeeping and Laundry acknowledged the service corridor Mechanical Room was not separated from other spaces by smoke resistant partitions.</p> <p>3.1-19(b)</p> <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 annual testing of emergency lighting in accordance with LSC 7.9 for 2 of 2</p>	K010046	K046 the battery operated emergency lights is inspected and tested annually The maintenance director keeps a testing log documenting results	12/19/2014

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	<p>battery powered lights for the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hr duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Emergency Light Maintenance Log" documentation for 2013 and 2014 with the Administrator during record review from 9:30 a.m. to 11:40 a.m. on 12/02/14, documentation of an annual test for battery powered emergency lights in the facility for not less than 1 ½ -hr duration for the most recent twelve month period was not available for review. The aforementioned documentation stated an "annual test" for two of two battery operated emergency lights in the facility was conducted as a "45 minutes test" on 06/16/14. Based on interview at the time of record review, the Administrator stated documentation</p>		<p>1) The battery operated emergency light log has been updated to include an annual 90 minutes test 2) All resident have the potential to be affected 3) Administrator in-serviced the maintenance director on testing and documentation of battery operated emergency lights 4)Monitoring results will be reported to the QA committee on an ongoing monthly basis</p>	

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K010066 SS=D	<p>of an annual test for two of two battery powered emergency lights in the facility for not less than 1 ½ -hr duration for the most recent twelve month period was not available for review. Based on observations with the Director of Housekeeping and Laundry during a tour of the facility from 11:40 a.m. to 2:50 p.m. on 12/02/14, one battery powered emergency light is located at the emergency generator location and a second battery operated emergency light was located in the transfer switch room and each light illuminated when their respective test button was pushed.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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>			

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	<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 and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container with a self closing lid at 2 of 2 outside areas where smoking was permitted. This deficient practice could affect two staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Director of Housekeeping and Laundry during a tour of the facility from 11:40 a.m. to 2:50 p.m. on 12/02/14, the outdoor smoking area located outside the kitchen exit had in excess of 30 extinguished cigarette butts deposited on the ground. In addition, the outdoor smoking area located outside the service corridor exit had in excess of twenty extinguished cigarette butts deposited on the ground. A metal container with a self closing cover device into which ashtrays can be emptied were not provided in these areas where staff smoking was taking place. Based on interview at the time of the observations, the Director of Housekeeping and Laundry acknowledged extinguished cigarette butts were deposited on the ground and a</p>	K010066	<p>K066 The facility has a no smoking policy for staff and a designated smoking area for residents 1) A smoking post metal ashtray has been provided for visitors 2) All residents and visitors have the potential to be affected maintenance director conducted walk through and observation of all areas outside kitchen exit and service corridor exit 3) Maintenance Director will monitor during daily rounds 4) Monitoring results will be reported to QA committee ongoing on a monthly basis</p>	12/19/2014

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K010147 SS=D	<p>metal container with a self closing cover device into which ashtrays can be emptied were not provided in these areas where staff smoking was taking place.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 1 of 1 extension cords including power strips 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 five staff and visitors in the Reception Office.</p> <p>Findings include:</p> <p>Based on observation with the Director of Housekeeping and Laundry during a tour of the facility from 11:40 a.m. to 2:50 p.m. on 12/02/14, a refrigerator and a microwave oven were plugged into an extension cord in the Reception Office. Based on interview at the time of observation, the Director of Housekeeping and Laundry acknowledged a power strip was utilized</p>	K010147	K147 the facility has a policy governing the use of extension cords used as a substitute for fixed wiring, 1) Extension cord found in reception office was removed by the maintenance director, 2) All residents and visitors have a potential to be affected, Maintenance director conducted a walk through inspection and observation of all areas of the facility to ensure extension cords are not being used as fixed wiring, 3) Maintenance director will inspect new residents rooms within 48 hours of admission to ensure extension cords are not being used 4) Monitoring results will be reported to QA committee on a monthly basis, anything less the 100% compliance will require an action plan for correction	12/19/2014

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	as a substitute for fixed wiring in the Reception Office. 3.1-19(b)				