STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155771	A. BUILDING 01 B. WING	08/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF	1070 W JEFFERSON ST FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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: 08/21/17 Facility Number: 001127 Provider Number: 155771 AIM Number: 200247220 At this Life Safety Code Survey, Franklin United Methodist Community Res. & Com. Care was found not in compliance with Requirements for Participation in Medicare/Medicaid, 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. The Franklin United Methodist Community consists of four separate but connected buildings constructed at four different times: Building 1 an NCC facility built in 1957, is a three story sprinklered building of Type I (332) construction with a basement; Building 2 built in 1980 is a three story sprinklered	K 0000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations the facility has taken and will take actions set forth in the Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that the deficiencies cited have been corrected by the date certain of September 15, 2017. The Facility requests a desk review of this Plan of Correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	building of Type I (332) construction with a basement; Building 3 built in 1992 is a one story sprinklered building of Type I (332) construction with a basement; and Building 4 built in 2000 is a three story sprinklered building of Type I (332) construction. Because all buildings are of the same type of construction, the facility was surveyed as one building. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. In Building 2, 47 battery operated detectors were provided in resident rooms in Health Center 2 and Health Center 3. All other resident rooms in Building 2 are provided with hard wired smoke detectors. In Building 3 and Building 4, hard wired smoke detectors are installed in all resident rooms. The healthcare portion of the facility has a capacity of 208 and had a census of 166 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/31/17 - DA			
K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation			

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	A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was installed in accordance with 19.3.4.1. NFPA 72, 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. A.17.7.4.1 states detectors should not be located in a direct airflow or closer than 36 inches. This deficient practice could affect staff and up to 28 residents, as well as staff and visitors in the Health Center (Building #2) second floor smoke compartment. Findings include: Based on observation with the Maintenance Manager on 08/21/17 at 11:21 a.m., the Health Center, also known as Building #2, second floor immediately outside resident rooms	K 0341	NFPA 101 Fire Alarm Systems – Installation Life Safety inspectors discovered a fire alarm system on Health Center (Building #2) second floor that was within thirty-six (36) inches of an air handler. The facility contacted AADCO Inc. for service and the fire alarm system described was moved more than thirty-six (36) inches from the air vent on August 25, 2017. Facility requested AADCO Inc. move five (5) other smoke detectors as precaution and to remain in compliance with Life Safety Code Standard. Photo of deficiency has been included along with photo reflecting proper compliance.	08/25/2017

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	#2201 and #2235 had a smoke detector approximately 18 inches from an air duct. Based on interview at the time of the observation, the Maintenance Manager agreed that the smoke detector was approximately 18 inches from an air duct. 3.1-19(b)			
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on record review with the	K 0346	NFPA 101 Fire Alarm Systems – Out of Service Life Safety inspectors discovered during record review and interview, the facility failed to provide proper contact information within the policy when fire alarm systems are out of service four (4) hours or more in a twenty-four (24) hour period. Policy was changed to reflect required practice of contacting the Indiana State Department of Health via the Gateway link at https://gateway.isdh.in.govas the primary method or by secondary	09/07/2017

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	Maintenance Manager on 08/21/2017 at 10:36 a.m., the facility provided fire watch plan documentation but it was incomplete. The plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov. as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Manager acknowledged the fire watch documentation provided named "Fire Watch" in section E-3.1 of the disaster manual stated to contact the Indiana State Department of Health at (317) 233-7712, and not via the Gateway link or at the e-mail address listed above. 3.1-19(b)		method when the ISDH Gateway is non-operational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Facility policy changed on September 7, 2017 to reflect required practice immediately and is included. All policy changes go through quarterly Quality Assurance Committee for approval or any further recommendations. This will occur on October 5, 2017, but policy changed for immediate use.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked			

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	b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon	K 0353	NFPA 101 Sprinkler System – Maintenance and Testing Life Safety inspectors discovered through review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. This information should document monthly the inspection, testing, and maintenance of water-based fire protection systems ensuring proper condition and normal water supply pressure is being maintained. Facility developed expected protocol for monthly sprinkler system inspection to visually inspect control valves to ensure that they are: *in the normal open position *accessible *properly sealed *locked and/or supervised *free from leaks *provided with appropriate signage identifying the portion of	08/22/2017

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	request. This deficient practice could affect all residents, staff, and visitors within the facility. Findings include: Based on review of Koorsen Fire and Security's "Sprinkler Inspection Report" documentation for the most recent twelve month period with the Maintenance Manager during record review from 9:10 a.m. to 10:50 p.m. on 08/21/17, monthly wet sprinkler system gauge inspection documentation for 52 weeks of the most recent 52 week period was not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for 12 months of the most recent 12 month period was not available for review. Based on interview at the time of record review, the Maintenance Manager acknowledged sprinkler system gauge and control valve inspection documentation for the aforementioned monthly periods was not available for review. 3.1-19(b)		the system they control Inspection will also include visually inspecting gauges on wet pipe systems to verify that they are in good condition and that normal water pressure is being maintained. The guidelines for inspection and monthly monitoring sheet are attached and will be reported to our quarterly Quality Assurance Committee for any further recommendation.	
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service			

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	Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed for the protection of 48 of 48 residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all occupants in the facility. Findings include:	K 0354	NFPA 10 Sprinkler System – Out of Service Life Safety inspectors discovered during record review and interview, the facility failed to provide proper contact information within the policy when the automatic sprinkler systems are out of service ten (10) hours or more in a twenty-four (24) hour period. Policy was changed to reflect required practice of contacting the Indiana State Department of Health via the Gateway link at https://gateway.isdh.in.govas the primary method or by secondary method when the ISDH Gateway is non-operational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Facility policy changed on September 7, 2017 to reflect required practice immediately and is included. All	09/07/2017

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	Based on record review with the Maintenance Manager on 08/21/17 at 10:36 a.m., the facility provided fire watch plan documentation but it was incomplete. The plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Manager acknowledged the fire watch documentation provided named "Fire Watch" in section E-3.11 stated to contact the Indiana State Department of Health at (317) 233-7712 and not via the ISDH Gateway link or at the e-mail address listed above. 3.1-19(b)		policy changes go through quarterly Quality Assurance Committee for approval or any further recommendations. This will occur on October 5, 2017, but policy changed for immediate use.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers			

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	are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and / or conduit through 1 of 8 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect 34 residents, 6 staff and 4 visitors. Findings include: Based on observations with the Maintenance Manager on 08/21/17 at 1:48 p.m., there was a three inch gap along the base of the barrier where the top of the wall met the bottom of the barrier in the smoke barrier wall in Building 2 on the third floor by resident rooms #2328. Based on interview at the time of observation, the Maintenance Manager acknowledged the gap along the bottom of the barrier wall, and stated that he would get the open area filled in and	K 0372	NFPA 101 Subdivision of Building spaces – Smoke Barrier Construction Life Safety inspectors discovered during observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. A three (3) inch gap was identified along the base of the barrier where the top of the wall met the bottom of the barrier in Building 2 on 3rd floor. Facility Maintenance Supervisor requested immediate correction with fire caulk being inserted to fill in three (3) inch gap around barrier. Photo of deficiency has been included along with photo reflecting proper compliance.	08/22/2017

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	closed up immediately. 3.1-19(b)			
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 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that 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	K 0374	NFPA 101 Subdivision of Building spaces – Smoke Barrier Doors Life Safety inspectors identified during observation and interview that facility failed to ensure smoke barrier doors would restrict the movement of smoke for at least twenty (20) minutes. Life Safety Code 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	08/24/2017

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	restrict the movement of smoke. This deficient practice affects 48 residents, as well as 6 staff and 4 visitors on the Health Center 2 north hall. Findings include: Based on observation on 08/21/17 at 11:26 a.m. with the Maintenance Manager, the Health Center 2 north hall set of smoke barrier doors had a one inch gap along the top where the doors came together in the closed position. Based on interview at the time of the observation, the Maintenance Manager verified and acknowledged that the barrier doors did not fully close, leaving the one inch gap near the top of the door set. 3.1-19(b)		restrict the movement of smoke. Facility Maintenance Supervisor requested immediate correction with adjustment of weather stripping to door meeting 1/8 inch requirement. Photo of deficiency has been included along with photo reflecting proper compliance.	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended.			

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	Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure trash and dirty linen receptacles near were maintained in accordance with 19.7.5.7. This deficient practice could affect up to 88 residents, as well as 12 staff and 8 visitors in the smoke compartment. Findings include: Based on observation with the Maintenance Director on 08/21/17 during a tour of the facility between 10:50 a.m. and 1:50 p.m. the following was noted: a) room 2235, an area with no door that is open to the corridor, had three 40 gallon containers holding trash, resident owned dirty linens, and dirty linens b) the alcove near resident rooms #2285 and 2283, an area with no door that is open to the corridor, had three 40 gallon containers holding trash, resident owned dirty linens, and dirty linens. c) room 2200, an area with no door that is open to the corridor, had three 40 gallon containers holding trash, resident owned dirty linens, and dirty linens	K 0754	NFPA 101 Soiled Linen and Trash Containers Life Safety inspectors discovered through observation and interview that facility failed to ensure trash and dirty linen receptacles were proper size and within proper location. Maintenance Supervisor worked with Director of Nursing to immediately correct situation with all receptacles greater than thirty-two (32) gallons moved to a room protected as a hazardous area when not attended. Keys to these locations were distributed to Director of Nursing, Assistant Director of Nursing, and Nurse Managers. Photo of deficiency has been included along with photo reflecting proper compliance.	09/13/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on interview at the time of each observation, the Maintenance Manager acknowledged each area was open to the corridor, did not have a door for separation, and the total amount of trash and soiled linens located in these areas exceeded the maximum amount allowable for soiled linens in of the corridor. 3.1-19(b)			
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99),			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155771	A. BUILDING 01 B. WING	08/21/2017

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	400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, it could not be assured 1 of 1 extension cords including power strips used in patient care vicinities met UL 1363A or UL 60601-1. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination or treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice could affect 2 residents, as well as staff and up to 4 visitors. Findings include: Based on observation with the Maintenance Manager on 08/21/17 at 11:15 a.m., an extension cord power strip was powering the resident bed in room #2213. This extension cord power strip was not UL 1363A or UL 60601-1 rated. When asked if there was documentation available for review to determine this finding, the Maintenance Manager said	K 0920	NFPA 101 Electrical Equipment – Power Cords and Extension Cords Life Safety inspectors identified through observation and interview, that facility failed to meet the requirement of power strips in the patient care vicinity may not be used for non-patient care related electrical equipment. Maintenance Supervisor corrected this immediately upon notification by the Life Safety inspector and in their presence. Compliance was obtained immediately. Facility will continue to enforce attached policy along with monthly monitoring of resident areas by Housekeeping Staff. Monthly monitoring sheet is attached. Education will continue to be provided to all staff through new staff orientation and on-going competency training. Those who frequent resident areas such as nursing and social service will be reminded to report items of non-compliance directly to Maintenance Supervisor for immediate correction.	08/21/2017

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	he did not even know where the extension cord power strip came from. Based on interview at the time of the observation, the Maintenance Manager acknowledged the resident bed being plugged into an extension cord power strip, and immediately unplugged and removed it from the area. 3.1-19(b)			