

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 11/14/2013
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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: 11/14/13</p> <p>Facility Number: 012225 Provider Number: 155780 AIM Number: 200983560</p> <p>Surveyors: Mark Caraher, Life Safety Code Specialist & Brett Overmyer, 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 a smoke</p>	K010000	Signature page via fax.	
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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>detector hard wired to the fire alarm system installed in resident sleeping Room 502 and has battery operated smoke detectors installed in all other resident sleeping rooms. The facility has a capacity of 130 and had a census of 74 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 Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/19/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010022 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 1 of 8 paths of egress was marked with an approved sign to make the direction of travel to reach the nearest exit apparent. LSC 7.10.1.2 requires exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. This deficient practice could affect 24 residents, staff and visitors in the facility if needing to exit the facility from the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the with the Maintenance Director during a tour of the facility from 12:40 p.m. to 3:50 p.m. on 11/14/13, the path of egress from the corridor by the Medical Records Office into the service corridor is not marked with an approved sign at the interior door set which serves as the entrance to the service corridor. The interior door set which serves as an entrance to the service corridor is held open by a magnetic device which releases upon activation of the fire alarm system. In addition, the</p>	K010022	<p>K022The facility has in place policies and procedures to identify exits, and ways to reach exits as a means of egress, with readily visible approved signage. (1)The exit sign needed to identify the service hallway as a means of egress has been installed. (2)All residents have the potential for being affected. Maintenance Director evaluated the facility to ensure all corridors have appropriate exit signs marking a means of egress and ways to reach them. (3)Maintenance Director will do a walk-about weekly to ensure egress signs are present and functional and document findings. (4)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.</p>	12/14/2013

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	<p>service corridor is marked as an exit for the Main Dining Room exit by the kitchen and the service corridor is also marked as an exit on the wall mounted floor plans of the facility. The service corridor exit by the Oxygen Storage room is marked with signage as a facility exit and is also marked as an exit on the wall mounted floor plans of the facility. Based on interview at the time of observation, the Maintenance Director acknowledged the path of egress from the corridor by the Medical Records Office to the service corridor is not marked with an approved sign at the interior door set which serves as the entrance into the service corridor.</p> <p>3.1-19(b)</p>			

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K010048 SS=C	<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 develop a written fire safety plan for staff response to the activation of battery operated smoke detectors installed in 77 of 78 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Disaster Action Plan: Fire Prevention, Fire Policy & Procedure" documentation with the Maintenance Director during record review from 9:10 a.m. to 11:40 a.m. on 11/14/13, the facility's written fire safety plan did not</p>	K010048	K048The facility has a written plan for the protection of all residents and for their evacuation in the event of an emergency including staff response to alarms; activation of the fire detection/suppression system; and fire containment. (1)The written fire and disaster plan has been modified by the administrator to specifically address staff response to the activation of battery operated smoke detectors in resident rooms. (2)All residents have the potential for being affected. An all staff inservice meeting was conducted on December 5th by the administrator addressing staff response to battery operated smoke detectors in resident rooms. (3)The administrator will review the written fire and disaster plan to coincide with monthly fire and disaster preparedness drills and whenever staff education is offered to ensure it is current. (4)The administrator will review the written fire and disaster plan to coincide with monthly fire and disaster preparedness drills and whenever staff education is offered to ensure it is current. Modifications will be approved by the QAPI Committee.	12/14/2013			

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	<p>include staff response to the activation of battery operated smoke detectors installed in each of 77 resident sleeping rooms. Based on observations with the Maintenance Director during a tour of the facility from 12:40 p.m. to 3:50 p.m. on 11/14/13, battery operated smoke detectors were installed in 77 of 78 resident sleeping rooms. Based on interview at the time of record review, the Maintenance Director acknowledged the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms.</p> <p>3.1-19(a)</p>			

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K010072 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure 4 of 8 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 70 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the with the Maintenance Director during a tour of the facility from 12:40 p.m. to 3:50 p.m. on 11/14/13, the following was noted:</p> <p>a. a three drawer wooden cabinet used to store personal protective equipment and supplies for isolation residents was stored in the corridor by Room 109, Room 202 and Room 609. Each cabinet was three feet high and extended two feet from the wall into the corridor and was placed in the means of egress for the 100 Hall, 200 Hall and 600 Hall. Each of the aforementioned halls are marked as facility exit access. Based on interview at the time of the observations, the Maintenance Director acknowledged the</p>	K010072	<p>K072The facility has in place policies and procedures to ensure corridors used as a means of egress in the case of fire or other emergency are maintained free of obstructions or impediments. (1)Cabinets observed containing personal protective equipment for isolation residents have been removed from the corridor. Linen and food services carts have been removed from the service corridor. (2) All residents have the potential to be affected. All staff will be inserviced December 5th, on location of PPE used for isolation residents. Housekeeping/Laundry and Dietary employees will be inserviced on December 2nd and 3rd on location of delivery carts to ensure the service corridor remains unobstructed. (3)Housekeeping, Dietary and Nursing supervisors will monitors halls to ensure they allow free passage on a daily basis. Managers on Duty will monitor on weekends. (4)Monitoring results will be reported to the QAPI Committee ongoing on a monthly</p>	12/14/2013			

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	<p>100 Hall, 200 Hall and 600 Hall were not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>b. three clean linen carts were stored in the service corridor by the Main Dining Room. One of the three carts was used to store clean linen and towels, was five feet tall by five feet long and extended four feet from the wall into the corridor. The other two carts were used to store clean clothes on hangars and were four feet tall by five feet long and extended three feet from the wall into the corridor. In addition, two empty resident meal carts each measuring five feet tall by five feet long extended three feet into the corridor from the wall. The service corridor is marked as an exit for the Main Dining Room exit by the kitchen and is also marked as an exit on the wall mounted floor plans of the facility. Based on interview at the time of the observations, the Maintenance Director stated the carts are not stored in the laundry or the kitchen and acknowledged the service corridor was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>3.1-19(b)</p>		<p>basis. Anything less than 100% compliance will require an action plan for correction.</p>	

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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 11 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available 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 "Generator Load Testing Log Sheet" documentation with the Maintenance Director during record review from 9:10 a.m. to 11:40 a.m. on 11/14/13, load testing documentation for emergency power transfer time for the twelve month period of November 2012 through October 2013 was not available</p>	K010144	<p>K144The facility generator is inspected and tested on a weekly basis. The Maintenance Director keeps a testing log documenting generator performance and results. (1)The generator testing log has been updated to include documenting transfer switch time from utility to emergency power. (2)All residents have the potential to be affected. Administrator inserviced the Maintenance Director on testing and documentation of the emergency generator. (3)Administrator will review the generator testing log to ensure procedures are followed and documented and transfer time is within ten seconds. (4)Monitoring results will be reported to the QAPI Committee ongoing on a monthly basis. Anything less than 100% compliance will require an action plan for correction.</p>	12/14/2013			

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	<p>for review. Review of SafeCare "Level 2 Inspection" documentation dated 10/17/13 indicated emergency power transferred to the emergency generator within 10 seconds. Based on interview at the time of record review, the Maintenance Director stated no additional generator transfer time documentation for emergency power transfer time was available for review and acknowledged emergency power transfer time was not documented for eleven of twelve months.</p> <p>3.1-19(b)</p>				

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K010147 SS=E	<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 2 of 2 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 28 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the with the Maintenance Director during a tour of the facility from 12:40 p.m. to 3:50 p.m. on 11/14/13, a refrigerator was plugged into a power strip in resident Room 701 and a 12 amp vending machine was plugged into a power strip in the employee break room. Based on interview at the time of the observations, the Maintenance Director acknowledged a power strip was in use as a substitute for fixed wiring for a refrigerator and a vending machine at each of the aforementioned locations.</p> <p>3.1-19(b)</p>	K010147	<p>K147The facility has a policy governing the use of power strips and procedures for monitoring there use. (1)Power strips from Vending machine in employee break room and refrigerator in room 701 were removed by the Maintenance Director. (2)All residents have the potential to be affected. Maintenance director conducted walk-through inspection and observation of all areas of the facility to ensure power strips are not being used unless specifically permitted. (3)Maintenance Director will inspect new resident rooms within 48-hours of admission to ensure power strips are not being utilized unless specifically permitted. Housekeeping will be inserviced on December 2nd regarding detection of prohibited power strips and reporting procedures. Maintenance Director will monitor during daily rounds. (4)Monitoring results will be reported to the QAPI Committee ongoing on a monthly basis. Anything less than 100% compliance will require an action plan for correction.</p>	12/14/2013			

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