STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	(X3) DATE SURVEY COMPLETED
	155717	A. BUILDING 01 / B. WING	08/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME - A WATERS COMMUNITY	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

(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: 08/24/15 Facility Number: 000376 Provider Number: 155717 AIM Number: 100275510 At this Life Safety Code survey, Alpha Home - A Waters Community 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. This one story facility was determined to be of Type V (111) 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 smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 86 and had	K 0000	Preparation and/or execution of the plan of correction ingeneral, or this corrective action in particular does not constitute anadmission agreement by the facility of the facts alleged or conclusions setforth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared andor executed in compliance with State and Federal laws. This POC is to serve as the Alpha Home AWaters Community's credible allegation of compliance.	

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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	a census of 28 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one detached storage shed.			
K 0018 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 3 of over 45 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 20 residents, staff and visitors. Findings include: Based on observations with the	K 0018	K018 It is the policy ofthe Alpha Home to ensure there is no impediment to door closure and corridordoors are provided with a means for suitable closure. Room 308 and cart storage room in the 400Hall were repaired with door latches. All doors were inspected to ensure suitable latches. No residents were affected. To prevent a re-occurrence, the maintenance director willdocument monthly inspection of doors to	09/23/2015

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	Administrator, Maintenance Director and the Maintenance Consultant during a tour of the facility from 12:40 p.m. to 2:30 p.m. on 08/24/15, the corridor door to the clean utility room by the entrance to the 100 Hall, Room 308 and the cart storage room in the 400 Hall each failed to latch into the door frame because the latching mechanism did not protrude into the latching plate on the door frame. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned corridor doors had an impediment to closing and latching into the door frame. 3.1-19(b)		ensure latching properly. The administrator or designee will review the facilitypreventative maintenance binder each month and report to the Quality AssuranceCommittee, monthly, ongoing to ensure compliance.	
K 0021 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 3 kitchen exit	K 0021	K021 It is the policy ofthe Alpha Home to only hold doors open with devices	09/23/2015

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	doors was held open only by a device arranged to automatically close upon activation of the fire alarm system. This deficient practice could affect 5 staff in the kitchen. Findings include: Based on observation with the Administrator, Maintenance Director and the Maintenance Consultant during a tour of the facility from 12:40 p.m. to 2:30 p.m. on 08/24/15, the door in the kitchen exit passage way to the rear exit of the kitchen was held in the fully open position with a door stop. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned door was propped open with a door stop and would fail to allow full closure automatically upon activation of the fire alarm system. 3.1-19(b)		arranged to automaticallyclose all such doors by activation of fire alarms. The door stops were removed and staffeducated. No other doors were found to be held open. No residents were affected. To prevent a reoccurrence, the maintenance director willconduct a monthly inspection to ensure door stops not being used. The maintenance director will document on themonthly preventative maintenance log. The administrator ordesignee will review the facility preventative maintenance binder each monthand report to the Quality Assurance Committee, monthly, ongoing, to ensurecompliance.	
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully			

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	ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 30 residents, staff and visitors. Findings include: Based on observations with the Administrator, Maintenance Director and the Maintenance Consultant during a tour of the facility from 12:40 p.m. to 2:30 p.m. on 08/24/15, the following openings were noted in the ceiling smoke barrier: a. the one and a half inch annular space surrounding each of six electrical conduits and a two inch in diameter open ended PVC pipe for the passage of cables penetrated the ceiling of the electrical room by Room 209. b. the one and a half inch annular space surrounding each of eight electrical conduits and a two inch in diameter open ended PVC pipe for the passage of cables penetrated the ceiling of the electrical room by Room 309. c. two, three inch in diameter holes in the storage room by the men's restroom in the corridor leading to the main entrance lobby.	K 0025	K025 It is the policy ofthe Alpha Home to maintain ceiling smoke barriers. Openings located in electrical room by Room209, by electrical room by 309, and storage room by men's restroom in corridorleading to the main entrance were caulked with fire approved product. To prevent a re-occurrence, the maintenance director hasbeen educated to inspect for smoke barrier penetrations following any buildingwork. The maintenance Director willdocument work performed and visual inspection to ensure no holes in smokebarriers, and submit to administrator for review. The Quality Assurance Committee will be responsible foroversight of maintenance director's compliance with visual inspection followingany building work performed, monthly, ongoing.	09/23/2015

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	Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned openings in the ceiling did not provide at least a one half hour fire resistance rating for the ceiling smoke barrier. 3.1-19(b)			
K 0029 SS=E Bldg. 01	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 1. Based on observation and interview, the facility failed to ensure 1 of 10 hazardous areas, such as combustible storage rooms over 50 square feet were, separated from other spaces by smoke resistant partitions. This deficient practice could affect 30 residents, staff and visitors in the vicinity of the electrical room containing the facility's automatic sprinkler system riser. Findings include:	K 0029	K029 It is the policy of the Alpha Home to maintain smokeresistant partitions. 1.Openings identified in sprinkler room have beenclosed with fire rated caulk. 2.Corridor doors to the cart storage room by 208and 400 hall cart storage room will be equipped with door closure devices. No residents were affected To prevent a re-occurrence, the maintenance director hasbeen educated on need for self-closure devices on rooms where	09/23/2015

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	Based on observations with the Administrator, Maintenance Director and the Maintenance Consultant during a tour of the facility from 12:40 p.m. to 2:30 p.m. on 08/24/15, the following openings were noted in two walls of the electrical room containing the facility's automatic sprinkler system riser which measured greater than fifty square feet in size and was used for storage of combustible boxes and supplies: a. two, eight inch in diameter holes were noted near an eight inch in diameter sprinkler pipe which penetrated the west wall. b. an eight inch by eight inch square hole for the passage of eight, one inch conduits in the north wall. c. an eight inch in diameter hole for the passage of a two inch in diameter water line in the north wall. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned holes in the electrical room were each not filled with an approved material to separate this hazardous area from other spaces with smoke resistant partitions. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure corridor doors to 3 of 10 hazardous areas such as soiled		hazardousmaterials are stored. The maintenance director will be required to inspect building,monthly, for hazardous storage and self-closure devices and document on themonthly maintenance log. The administrator will review and report compliance to theQuality Assurance Committee, who will be responsible for facility compliance,monthly, ongoing.	

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	linen rooms and combustible storage rooms over 50 square feet were provided with self closing devices. This deficient practice could affect 30 residents, staff and visitors. Findings include: Based on observations with the Administrator, Maintenance Director and the Maintenance Consultant during a tour of the facility from 12:40 p.m. to 2:30 p.m. on 08/24/15, the corridor door to the Cart Storage room by Room 208 and the 400 Hall Cart Storage Room were each not equipped with a self closing device. Each of the aforementioned cart storage rooms contained two 32 gallon carts with soiled linen. In addition, the corridor door to the 400 Hall storage room which measured 66 square feet is size and was used for combustible storage was not equipped with a self closing device. Based on interview at the time of the observations, the Maintenance Director acknowledged the corridor doors to the aforementioned soiled linen and combustible storage rooms were not equipped with self closing devices. 3.1-19(b)			
K 0046 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour			

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	duration is provided in accordance with 7.9. 19.2.9.1. 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 1 battery powered lights for 9 of 12 months. 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. 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. Findings include: Based on review of "Battery Operated Emergency Lights" documentation with the Maintenance Director and the Maintenance Consultant during record review from 10:00 a.m. to 12:40 p.m. on 08/24/15, documentation of monthly functional testing for the battery powered emergency light located at the emergency generator for the nine month period of August 2014 through April 2015 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged	K 0046	K046 It is the policy of the Alpha Home to test and document batteryoperated emergency light testing at a minimum of every 30 days. A new battery operated light was installedto shine on the generator. No residents were affected. To prevent a reoccurrence, the maintenance director will check anddocument inspections every 30 days and maintained in maintenance binder. The administrator or designee will review the facility preventativemaintenance binder each month to ensure appropriate testing is completed andreport to the Quality Assurance Committee, monthly, ongoing to ensure facilitycompliance.	09/23/2015

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	monthly functional testing for the battery powered emergency light located at the emergency generator was not available for review for the nine month period of August 2014 through April 2015. Based on observation with the Administrator and the Maintenance Director during a tour of the facility at 2:50 p.m. on 08/24/15, the battery powered emergency light at the emergency generator location failed to operate when its respective test button was depressed five times. 3.1-19(b)			
K 0048 SS=D Bldg. 01	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 include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that 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	K 0048	K048 It is the policy ofthe Alpha Home to have a written plan on use of kitchen fireextinguishers. The policy was availableduring survey, but was not located in the nurse binder. The K extinguisher policy has been added tothe nurse's station emergency plan binder. The emergency plan will be updated annually to prevent are-occurrence. The administrator or designee will be responsible forensuring emergency plans are current. The Quality Assurance Committee will oversee annual review for facilitycompliance.	09/23/2015

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	(7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect 5 staff in the kitchen. Findings include: Based on review of "Disaster Plan" and "Disaster Policy & Procedure" documentation with the Maintenance Director and the Maintenance Consultant during record review from 10:00 a.m. to 12:40 p.m. on 08/24/15, the written fire safety plan available to staff at the nurses station did not address the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The Maintenance Director's life safety code documentation included the use of the K Class extinguisher but it was not included in the version available to staff at the nurses station. Based on interview at the time of record review, the Maintenance Director acknowledged the written fire safety plan available to staff at the nurses station did not address the use of the K class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on observation with the Administrator, Maintenance Director and the Maintenance Consultant during a tour			

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	of the facility from 12:40 p.m. to 2:30 p.m. on 08/24/15, one K class fire extinguisher was located in the kitchen. 3.1-19(a)			
K 0050 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD 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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to document activation of the fire alarm system for second shift fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility. Findings include:	K 0050	K050 It is the policy ofthe Alpha Home to hold fire drills as required by Life Safety standards. On 8/31/15, a fire drill was held with fire alarmactivation. The maintenance directorhas been educated on the need to actually pull alarms with exception of a codedannouncement, only between hours of 9 PM and 6 AM. No residents were affected. To prevent a re-occurrence, the administrator or designeewill review all fire drills and report to Quality Assurance Committee who willoversee facility compliance, monthly, ongoing.	09/23/2015

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	Based on review of "Fire Drill Report" documentation with the Maintenance Director and the Maintenance Consultant during record review from 10:00 a.m. to 12:40 p.m. on 08/24/15, documentation for the second shift fire drill conducted on 03/16/15 at 3:15 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal. The aforementioned fire drill documentation stated "Announcement," in response to "Fire Alarm Activation Method." In addition, "Fire Alarm Tested, Monitoring Company Received Signal, and Verified" had no response or entry listed for the fire drill. Based on interview at the time of record review, the Maintenance Director acknowledged documentation for the aforementioned second shift fire drill conducted after 6:00 a.m. but before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal. 3.1-19(b) 3.1-51(c)			
K 0056 SS=F Bldg. 01	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			

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	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 Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 3 combustible exterior canopies wider than 4 feet. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect all residents, staff and visitors if needing to exit the facility from the front entrance. Findings include: Based on observation with the Administrator, Maintenance Director and the Maintenance Consultant during a tour of the facility from 12:40 p.m. to 2:30 p.m. on 08/24/15, the larger and taller exterior canopy which is attached to the shorter and smaller canopy at the front entrance which is attached to the building consisted of wood paneling on the underside of the canopy and wood trim and measured twenty feet wide and twenty feet long. The area underneath the canopy was not provided with	K 0056	K056 It is the policy ofthe Alpha Home to maintain sprinkler coverage. Safe-care to install sprinkler head into the canopy area identified byinspector. No residents were affected. To prevent a re-occurrence, maintenance will do monthlyinspection of sprinkler heads to ensure sprinkler heads are functional. This will be documented monthly. The Quality Assurance Committee will be responsible foroversight of Maintenance director compliance, monthly, ongoing.	09/23/2015

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	155717		08/24/2015

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	automatic sprinklers. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned canopy extended more than four feet from the building, was of combustible construction and was not provided with automatic sprinklers. 3.1-19(b) 3.1-19(ff)			
K 0062 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler systems was inspected every five years as required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 10-2.2 states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient	K 0062	K062 It is the policy ofthe Alpha Home to ensure automatic sprinkler and fire hydrant testing performedaccording to Life Safety Standards and sprinkler heads unobstructed. Pipe Sprinkler Company had already completed pipeinspections, but documentation was not on site at time of inspection. Documentation will be placed in Fire SafetyBinder, for inspector's review. Safe-care to perform fire hydrant testing. Sprinkler heads observed by room 209, 109, and 113 have beencleared of obstruction. All sprinklerheads have been inspected to ensure free of obstruction. No residents were affected.	09/23/2015

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	practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director and the Maintenance Consultant from 10:00 a.m. to 12:40 p.m. on 08/24/15, documentation of an internal pipe inspection for the facility's automatic sprinkler system within the most recent five year period was not available for review. Based on observation with the Administrator, Maintenance Director and the Maintenance Consultant during a tour of the facility from 12:40 p.m. to 2:30 p.m. on 08/24/15, 10/07/14 and, 05/15/09 was written on the sprinkler system riser as the dates of the most recent internal pipe inspections. Based on interview at the time of record review and of the observation, the Maintenance Director stated sprinkler piping in the facility had been replaced due to flushing the sprinkler system within the last month but acknowledged documentation of the results of the most recent internal pipe inspection and the documentation of the date and extent of sprinkler system flushing was not available for review. 3.1-19(b)		To prevent a re-occurrence, after each site visit from firesystem inspectors, administrator or designee will ensure documentation iscollected and obtained and placed in Fire Safety Binder. Fire Hydrant Testing will be required annually. Sprinkler heads will be observed monthly by maintenancedirector for any obstruction and inspection documented on maintenance log. The administrator will review monthly logs and fireinspections as applicable and report need for any fire safety inspections tothe Quality Assurance Committee, who will oversee facility compliance, monthly,ongoing.	

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	2. Based on record review, observation and interview; the facility failed to ensure 2 of 2 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of SafeCare "Fire Hydrant Inspection Report" documentation dated 05/30/14 and "Service Call Report" dated 08/21/15 with the Maintenance Director and the Maintenance Consultant during record from 10:00 a.m. to 12:40 p.m. on 08/24/15, documentation of fire hydrant inspection for two facility fire hydrants within the most recent twelve month period was not available for review. Safecare's 08/21/15 "Service Call Report" documentation stated "could not perform hydrant test." Based on interview at the time of record review, the Maintenance			

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	Director stated Safecare could not perform the hydrant test because they did not have the correct tool to open the hydrant. The Maintenance Director acknowledged documentation of facility owned fire hydrant inspection within the most recent twelve month period was not available for review. Based on observation with the Administrator, Maintenance Director and the Maintenance Consultant during a tour of the facility from 12:40 p.m. to 2:30 p.m. on 08/24/15, two facility owned fire hydrants were noted on the premises. 3.1-19(b) 3. Based on observation and interview, the facility failed to replace 3 of over 100 sprinklers which had become corroded, had paint, lint or other foreign materials on them. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 16 residents, staff and visitors.			

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	Findings include: Based on observations with the Administrator, Maintenance Director and the Maintenance Consultant during a tour of the facility from 12:40 p.m. to 2:30 p.m. on 08/24/15, paint was on the pendant sprinkler in the corridor outside Room 209. In addition, the pendant sprinklers installed in the corridor outside Room 109 and 113 were wrapped with silver duct tape to prevent paint from being applied to each sprinkler. Based on interview at the time of the observations, the Maintenance Director stated the 100 Hall was being renovated which included painting and acknowledged the aforementioned sprinklers had foreign materials on them. 3.1-19(b) 4. Based on observation and interview, the facility failed to ensure 6 of over 100 sprinkler heads were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect 16 residents, staff and visitors. Findings include:			

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	Based on observations with the Administrator, Maintenance Director and the Maintenance Consultant during a tour of the facility from 12:40 p.m. to 2:30 p.m. on 08/24/15, the escutcheon plate was missing for automatic sprinklers located in the following areas: a. for three sprinklers in the 100 Hall electrical room. b. for one sprinkler in the 100 Hall oxygen storage and transfilling room. c. for one sprinkler in the Housekeeping Closet by Room 207. d. for one sprinkler in the Accounting Office. Based on interview at the time of the observations, the Maintenance Director acknowledged an escutcheon was missing for the aforementioned automatic sprinkler locations. 3.1-19(b)			
K 0076 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside.			

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	NFPA 99 4.3.1.1.2, 19.3.2.4 1. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3,000 cubic feet are vented to the outside by a dedicated mechanical ventilation system or by natural venting. If natural venting is used, the vent opening or openings shall be a minimum of 72 square inches in total free area. This deficient practice could affect five staff and visitors in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observation with the Administrator, Maintenance Director and the Maintenance Consultant during a tour of the facility from 12:40 p.m. to 2:30 p.m. on 08/24/15, the oxygen storage and transfilling room in the 100 Hall which was used to store two liquid oxygen containers was not provided with continuous mechanical ventilation. A mechanical vent was observed in place on the ceiling in the room but the mechanical vent was inoperable. Based on interview at the time of observation, the Maintenance Director acknowledged the oxygen storage and transfilling room was not provided with continuous mechanical ventilation or with natural vent openings of greater than 72 square	K 0076	K076 It is the policy ofthe Alpha Home to maintain an oxygen storage room according to Life Safetystandards. The light switch to be placed at a minimum of 5 feet abovefloor. Continuous mechanical vent to be placed in ceiling, andconnected to separate power switch. No residents were affected. To prevent a re-occurrence, the maintenance director willinspect the oxygen storage room, monthly to ensure continuous mechanical ventoperable. Quality Assurance Committee will oversee MaintenanceDirector's compliance on a monthly basis, ongoing.	09/23/2015

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	inches in total free area. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical wall fixtures in the oxygen storage and transfilling room was located at least five feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage. This deficient practice could affect five staff and visitors in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observation with the Administrator, Maintenance Director and the Maintenance Consultant during a tour of the facility from 12:40 p.m. to 2:30 p.m. on 08/24/15, one light switch was located on the wall 48 inches (4 feet) above the floor in the oxygen storage and transfilling room in the 100 Hall. Two liquid oxygen storage containers were observed stored in the room. Based on			

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	interview at the time of observation, the Maintenance Director acknowledged the aforementioned electrical wall fixture was located on the wall less than five feet above the floor of the oxygen storage and transfilling room in the 100 Hall. 3.1-19(b)			
K 0143 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage and transfilling rooms was provided with continuous mechanical ventilation. This deficient practice could affect 24 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room. Findings include:	K 0143	K143 It is the policy ofthe Alpha Home to maintain an oxygen storage room according to Life Safetystandards. Continuous mechanical vent to be placed in ceiling, andconnected to separate power switch. No residents were affected. To prevent a re-occurrence, the maintenance director willinspect the oxygen storage room, monthly to ensure continuous mechanical	09/23/2015

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	Based on observation with the Administrator, Maintenance Director and the Maintenance Consultant during a tour of the facility from 12:40 p.m. to 2:30 p.m. on 08/24/15, the oxygen storage and transfilling room in the 100 Hall which was used to store two liquid oxygen containers was not provided with continuous mechanical ventilation. Based on interview at the time of observation, the Maintenance Director acknowledged the oxygen storage and transfilling room was not provided with continuous mechanical ventilation. 3.1-19(b)		ventoperable. Quality Assurance Committee will oversee MaintenanceDirector's compliance on a monthly basis, ongoing.	
K 0144 SS=F Bldg. 01	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. 1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 4 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.	K 0144	K144 It is the policy of theAlpha Home to perform generator testing according to Life SafetyStandards. 1. Safecare was on site on 9/1/2015 and performedLevel I and level II, per manufacturer's recommendation generator load testing(Exhibit A). 2. Maintenance will conduct monthly load testingfor 30 minutes each month and document according to load testing requirements(Exhibit B). 3. Maintenance will perform	09/23/2015

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	Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Generator Exercise Log Weekly Operational Test" documentation with the Maintenance Director and the Maintenance Consultant during record review from 10:00 a.m. to 12:40 p.m. on 08/24/15, the following		weekly generator(Exhibit C). 4. Safecareinstalled a battery operated light to shine on the generator. Maintenance will complete weekly battery(testing) of generator emergency lighting and document such inspections(Exhibit C). To prevent are-occurrence, the Administrator or Designee will review monthly generator loadtesting logs and weekly battery inspections on generator emergencylighting. The Quality Assurance Committee will oversee the maintenancedirector for compliance, monthly, ongoing.	

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	was noted: a. documentation of monthly load testing for April 2015 was not available for review. b. documentation of monthly load testing on 05/19/15, 06/09/15 and 07/21/15 did not record the monthly load test as less than or above than 30% of the Emergency Power Supply (EPS) nameplate rating. In addition, each of the aforementioned monthly load tests did not document the test was under operating temperature conditions or at loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Based on interview at the time of record review, the Maintenance Director acknowledged monthly load testing documentation for April 2015 was not available for review and was incomplete for May, June and July 2015. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 8 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of			

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	not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. 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. Findings include: Based on review of "Emergency Generator - Weekly Inspection Checklist" documentation with the Maintenance Director and the Maintenance Consultant during record review from 10:00 a.m. to 12:40 p.m. on 08/24/15, documentation of weekly inspections of the starting batteries for the emergency generator for the weeks of 05/25/15, 06/01/15, 06/08/15 and 06/22/15 through 07/20/15 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of weekly inspections of the starting batteries for the emergency			

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	generator for the aforementioned eight week period was not available for review. 3.1-19(b) 3. Based on observation and interview, the facility failed to provide adequate emergency task lighting in and around the generator set in accordance with NFPA 101, 2000 Edition, Life Safety Code. Section 19.2.9.1 states emergency lighting shall be provided in accordance with Section 7.9. LSC Section 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires the EPS (Emergency Power Supply) equipment location shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Administrator and the Maintenance Director during a tour of the facility at 2:50 p.m. on 08/24/15, the battery powered emergency light at the emergency generator location failed to			

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ALPHA HOME - A WATERS COMMUNITY	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

(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
	operate when its respective test button was depressed five times. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned battery operated emergency light failed to illuminate. 3.1-19(b)			
K 0147 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of 2 main electrical rooms. NFPA 70, Article 100-26(a) states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 100-26(a) (1), (2) and (3). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 100-26(b) states the working space required by this section shall not be used for storage. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0147	K147 It is the policy ofthe Alpha Home to maintain electrical wiring and equipment in accordance withNFPA 70. All metal shelving was moved 3feet from electrical wiring and sprinkler system. No residents were affected. To prevent a re-occurrence, the maintenance director waseducated on keeping electrical boxes and sprinkler systems free and clear ofimpediments at a distance of at least 3 feet. The maintenance director will check monthly to ensure wiringand sprinkler system clearance of 3 feet is maintained. The Quality Assurance Committee will be responsible foroversight of Maintenance Director's compliance, monthly, ongoing.	09/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155717		08/24/2015

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	Based on observation with the Administrator, Maintenance Director and the Maintenance Consultant during a tour of the facility from 12:40 p.m. to 2:30 p.m. on 08/24/15, metal shelves storing eight buckets of floor finish were placed less than three feet from five electrical panels one of which contained the facility's fire alarm system breaker in the electrical room containing the facility's automatic sprinkler system riser. Based on interview at the time of observation, the Maintenance Director acknowledged shelving for materials storage was placed within three feet of the working space in front of the enclosed electrical panels in the aforementioned electrical room. 3.1-19(b)			
K 0154 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed in the event the automatic	K 0154	K154 It is the policy of the Alpha Home to maintain a fire watchpolicy. The facility did have a firewatch policy, in the maintenance director's manual,	09/23/2015

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	sprinkler system has to be placed out of service for four hours or more in a 24 hour period. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Disaster Plan" and "Disaster Policy & Procedure-Fire Watch Policy & Procedure" documentation with the Maintenance Director and the Maintenance Consultant during record review from 10:00 a.m. to 12:40 p.m. on 08/24/15, the written fire watch policy in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period was not included in the facility's written fire safety plan available to administration and nursing staff. The facility's written fire watch policy is included in the Maintenance Director's life safety code documentation but is not included in the version available to staff at the nurses station. Based on interview at the time of		but the policy was notavailable at the nurses' station at the time of the inspection. The Disaster Plan book at the nurses' stationwill be updated with fire watch policy. No residents were affected. To prevent a re-occurrence, the Disaster Policy Manuals willbe inspected annually. The QualityAssurance Committee will be responsible for ensuring annual compliance withinspection of Disaster Policy Manuals.	

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	record review, the Maintenance Director acknowledged the facility's written fire watch policy is included in the Maintenance Director's life safety code documentation but is not included in the version available to staff at the nurses station. 3.1-19(b)			
K 0155 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to provide a written policy containing 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 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Disaster Plan" and "Disaster Policy & Procedure-Fire Watch Policy & Procedure" documentation with the Maintenance Director and the	K 0155	K155 It is the policy of the Alpha Home to maintain a fire watchpolicy. The facility did have a firewatch policy, in the maintenance director's manual, but the policy was notavailable at the nurses' station at the time of the inspection. The Disaster Plan book at the nurses' stationwill be updated with fire watch policy. No residents were affected. To prevent a re-occurrence, the Disaster Policy Manuals willbe inspected annually. The QualityAssurance Committee will be responsible for ensuring annual compliance withinspection of Disaster Policy Manuals.	09/23/2015

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	Maintenance Consultant during record review from 10:00 a.m. to 12:40 p.m. on 08/24/15, the written fire watch policy in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period was not included in the facility's written fire safety plan available to administration and nursing staff. The facility's written fire watch policy is included in the Maintenance Director's life safety code documentation but is not included in the version available to staff at the nurses station. Based on interview at the time of record review, the Maintenance Director acknowledged the facility's written fire watch policy is included in the Maintenance Director's life safety code documentation but is not included in the version available to staff at the nurses station. 3.1-19(b)			