STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155651	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 05/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEVIEW CENTER OF FRANKLIN	651 S STATE 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
K010000	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: 05/22/13 Facility Number: 000353 Provider Number: 155651 AIM Number: 100291330 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Homeview Center of Franklin 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 NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. The original building consisting of 100, 200, 400 and 600 halls was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility consists of two sections: the original building built in 1985 determined to be of Type V (111) construction was fully sprinklered and the New Wing addition added to the south of	K010000	This plan of correction is submitted in compliance and conformance with State and Federal requirements. This plan of correction is not an admission to nor does it signify agreement with the survey allegations, rather it is submitted because it is required. This survey report does not present an accurate depiction of the manner in which nursing care, plant operations and other services are provided to this facility's residents.	

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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	the original building in 2005 is of Type V (111) construction and sprinklered. Because the original building and the addition are 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, spaces open to the corridors and hard wired smoke detectors in resident sleeping rooms. The facility has a capacity of 115 and had a census of 103 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one shed used for facility storage of equipment is not sprinklered. Quality Review by Dennis Austill. Life Safety Code Supervisor on 05/24/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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
	155651		05/22/2013

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K010018 SS=E	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 observations and interview, the facility failed to ensure corridor doors could latch into their door frames in 2 of 3 double leaf corridor doors. This deficient practice affects 22 residents on 300 hall and 12 residents on 100 hall as well as visitors and staff. Findings include: Based on observation on 05/22/13 during the tour between 12:15 p.m. to 3:00 p.m., the following double door sets required one door to be latched manually into the door frame before the second door would latch into the first door and secure them both tightly into the door frame: a. The double leaf corridor doors leading into Therapy on 300 hall	K010018	1. Self Closure devices have been purchased and installed on the Therapy doors which will enable the Therapy Doors on the 300 hall way to close and latch independently into the door frame.2. The self closure and latch adjustment of the Laundry Door by the Maintenance Supervisor has increased the speed of the door and now latches independtly into the door frame.3. No residents were affected, but now with the new installation of therapy doors self closures and maintenance work order door this system is in compliance with k18. 4. The laundry and therapy door will be audited for 4 weeks and results brought to the QA Committee.5. The Maintenance Supervisor will audit these two door locations weekly times four	06/21/2013

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	b. The corridor door leading into the Laundry corridor would not latch into its frame Based on interview on 05/22/13 concurrent with the observations, it was acknowledged by the Maintenance Supervisor, each of the aforementioned corridor doors could not latch or would not latch independently into the door frame. 3.1-19(b)		weeks and report to Administrator and all findings will be submitted to QA.6. This purchase, installation and maintenance work order will be completed by 6/21/13	

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K010029 SS=E	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 Based on observation and interview, the facility failed to ensure 1 of 2 corridor doors leading to hazardous areas such as rooms with combustible items was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 22 residents on 200 west hall which is adjacent to the Laundry corridor as well as visitors and staff. Findings include: Based on observation on 05/22/13 at 2:55 p.m. with the Maintenance Supervisor, the corridor door leading into the Supply room on Laundry corridor had a closing device on the door, however, when the door was released from an open position the door failed to close completely and latch into it's door frame. Based on	K010029	1. The supply room on the Laundry Cooridoor is being completely replaced. A 90 minute rated metal door with self closure has been ordered and installed by 6/21/13.2. No affects have been found to the residents on 200 hall and the steps to change out the entire door and self closure improves the fire rating and protection.3. The purchase and installation will resolve any issue and insures correction. The door will be placed on a four week audit system to assure the new self closure works with the door and continue to latche properly.4. The Maintenance Supervisor will use this four week audit and submit his finding to the Administrator.5. The Administrator will share any issues from Audit with the QA Committee. The system change is affective 6/21/13	06/21/2013

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	interview on 05/22/13 at 2:57 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned corridor door would not completely close and latch into it's door frame. 3.1-19(b)			

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K010038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observations and interview, the facility failed to ensure 2 of 9 exit doors with electromagnetic locks remained unlocked until the fire alarm system was reset. LSC 7.2.1.6(d) requires doors shall automatically unlock and remain unlocked until the fire protective signaling system has been manually reset. This applies to electromagnetic locks on all doors to unlock upon actuation of an approved fire alarm system installed in accordance with LSC 9.6. LSC 9.6.1.4 requires a fire alarm system to be installed, tested and maintained in accordance with NFPA 72, the National Fire Alarm Code. NFPA 72, 3-9.7.2 requires all emergency exits connected to the fire alarm system unlock upon receipt of any fire alarm signal by the fire alarm system serving the protected premises. This deficient practice could affect 22 residents on 200 hall west as well as staff and visitors. Findings include: Based on observation on 05/22/13 at 3:10 p.m. during a fire alarm test with the Maintenance Supervisor the electromagnetic locks on 200 hall west	K010038	1. The 200 hall way west door and the 200 hall way north door electromagnetic locks has been rewired and hooked into the fire alarm system. As of 6/21/13 when the fire alarm system is alarmed the doors are released.2. No residents have been negatively affected.3. The Alzheimers doors now has been rewired, with this work order, the change is perminent.4. The Administrator or desginee will monitor by completing a test/audit of the fire alram system every month at the fire drill test.5. This maintenance service was completed on or before 6/21/13.	06/21/2013

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	and 200 hall north did not release upon activation of the fire alarm system. Based on interview on 05/22/13 at 3:30 p.m. it was acknowledged by the Maintenance Supervisor the aforementioned exit doors equipped with electromagnetic locks remained locked when the fire alarm system was activated. 3.1-19(b)			

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K010056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observations and interview, the facility failed to ensure sprinkler heads were spaced a minimum of 6 feet apart for 1 of 1 automatic sprinkler systems NFPA 13, Section 5-6.3.4, " Minimum Distance between Sprinklers ", states sprinklers shall be spaced not less than 6 feet on center. In addition, LSC 19.1.1.4.5 requires minor renovations, alterations, modernizations, or repairs shall not reduce life safety below the level that previously existed. This deficient practice could affect 22 residents on 200 hall west as well as staff or visitors. Findings include: Based on observation on 05/22/13 at 1:40 p.m. with the Maintenance Supervisor, room # 203 had two sprinkler heads	K010056	1. SafeCare electronics came and serviced the sprinkler system. In room 203 the room was over sprinkled, therefore SafeCare capped of one sprinkler head in the center of room so the spacing is not less then 6 feet on center.2. No residents on 200 hall way or throughout the center has been negatively affected.3. An audit was completed with the Life Safety Code inspector and no other over sprinked area were found in the center.4. The SafeCare company capped the sprinkler which has resolved this regulation. The fire alarm system is tested quarterly by SafeCare.5. The Administrator will assure these quarterly SafeCare test continue.6. The Sprinkler was capped in room 203 on 6/21/13.	06/21/2013

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	which were measured to be four and one half feet located on the east side wall of the resident room. Based on interview on 05/221/13 at 1:44 p.m. with the Maintenance Supervisor, it was acknowledged the two sprinkler heads observed were less than six feet apart. 3.1-19(b)			

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K010062 SS=F	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 observation, record review and interview; the facility failed to ensure 1 of 1 pressure gauges for the sprinkler system in Riser room #1 were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on observation on 05/22/13 at 11:38 a.m. with the Maintenance Supervisor, one pressure gauge in sprinkler riser room #1 located on 300 hall east had a manufacturer's date of 2003. Based on Sprinkler Inspection Records review on 05/22/13 at 03:55 p.m., documentation did not reveal the sprinkler system gauge had been calibrated or the date of installation.	K010062	1. Maintenance Supervisor purchased and installed new sprinkler system gauge. The gauge was replaced completely.2. Plumbing Supply Store of Indianapolis shipped additional Sprinkler heads and these were added to replacement boxes in the riser rooms.3. No residents have been negatively affected.4. The gauge will be marked to replace it by May 2018, to meet the five year code.5. The purchase of the new gauge and additional sprinkler head ensures the no deficient practice.6. This change was completed on 6/21/13.	06/21/2013

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	Based on interview on 05/22/13 at 3:56 p.m. with the Maintenance Supervisor, it was acknowledged the pressure gauge had exceeded the five year requirement for recalibration or replacement. 3.1-19(b) 2. Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers in 1 of 2 riser rooms in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect 22 residents on 200 hall east including staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement. Findings include: Based on observation on 05/22/13 at			

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	11:45 a.m. with the Maintenance Supervisor, there only one side mount sprinkler head in the spare sprinkler cabinet in Riser #2 on 200 hall west. Based on interview on 05/22/13 at 11:50 a.m. with the Maintenance Supervisor, it was acknowledged the spare sprinkler cabinet located in Riser #2 did not have a minimum of two sidewall mount sprinkler heads available. 3.1-19(b)			

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K010069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure the grease filters on 1 of 1 kitchen stove hoods was properly positioned to drain the grease into the containers. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1998 Edition, at 3.2.7 says grease filters requiring a specific orientation to drain grease shall be clearly so designated, or the hood shall be constructed so filters cannot be installed in the wrong orientation. This deficient practice could affect kitchen staff and any residents or visitors in the adjoining dining room. Findings include: Based on observation on 05/22/13 at 12:30 p.m. with the Maintenance Supervisor, the grease filter baffles in hood above the gas grill in the Main kitchen were installed horizontally to drain grease from the exhaust hood. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the baffle grease filters were not installed in the correct orientation.	K010069	1. Homeview uses a company called Preventative Maintenace Service to service the kitchen hood system. PMS replaced the ventilation grease filter baffles in the hood. The company made a mistake and installed the horizontal baffles. As of 6/21/13 PMS was called and the vertical filter baffles were installed.2. No residents were negatively affected.3. The filter baffles are replaced only once a year by PMS which was notified and corrected immediately.4. The Administrator or designee will audit after each annual service before exiting our building upon service that vertical filter baffles are correct.5. This change was corrected on or before 6/21/13.	06/21/2013

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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
	the original building in 2005 is of Type V (111) construction and sprinklered. Because the original building and the addition are 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, spaces open to the corridors and hard wired smoke detectors in resident sleeping rooms. The facility has a capacity of 115 and had a census of 103 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one shed used for facility storage of equipment is not sprinklered. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K020018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 Based on observations and interview, the facility failed to ensure corridor doors could latch into their door frames in 2 of 3 double leaf corridor doors. This deficient practice affects 22 residents on 300 hall and 12 residents on 100 hall as well as visitors and staff. Findings include: Based on observation on 05/22/13 during the tour between 12:15 p.m. to 3:00 p.m., the following double door sets required one door to be latched manually into the door frame before the second door would latch into the first door and secure them both tightly into the door frame: a. The double leaf corridor doors leading into Therapy on 300 hall b. The corridor door leading into the Laundry corridor would not latch into its frame Based on interview on 05/22/13 concurrent with the observations, it was acknowledged by the Maintenance Supervisor, each of the aforementioned corridor doors could not latch or would	K020018	1. Self Closure devices have been purchased and installed on the Therapy doors which will enable the Therapy Doors on the 300 hall way to close and latch independently into the door frame.2. The self closure and latch adjustment of the Laundry Door by the Maintenance Supervisor has increased the speed of the door and now latches independtly into the door frame.3. No residents were affected, but now with the new installation of therapy doors self closures and maintenance work order door this system is in compliance with k18. 4. The laundry and therapy door will be audited for 4 weeks and results brought to the QA Committee.5. The Maintenance Supervisor will audit these two door locations weekly times four weeks and report to Administrator and all findings will be submitted to QA.6. This purchase, installation and maintenance work order will be completed by 6/21/13	06/21/2013

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	not latch independently into the door frame. 3.1-19(b)			

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K020143 SS=E	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 Oxygen storage rooms where oxygen transfer occurs had a working electrically powered exhaust vent. This deficient practice could affect 21 residents on the 300 hall east hall as well as visitors and staff near the oxygen storage room. Findings include: Based on observation on 05/22/13 at 1:02 p.m. with the Maintenance Supervisor, the electrically powered exhaust vent in the oxygen transfill room on 300 hall east was not working. Based on interview on 05/22/13 at 1:06 p.m. it was acknowledged by the Maintenance Supervisor oxygen transfer occurs in the	K020143	1. The Maintenance Supervisor serviced the exhaust fan and is working in the oxygen transfill room. The current exhaust fan is working but a larger CFM fan will be purchased and installed.2. No residents have been negatively affected.3. The new exhaust fan will be audited for four weeks. This audit will be submitted to the Administrator and the QA Committee.4. The new exhaust fan has a year warranty but normally last for over ten years or more. 5. This change was completeted on or before 6/21/13.	06/21/2013

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	Oxygen transfill room and the exhaust vent was not working. 3.1-19(b)			