

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155793	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/18/2015
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NAME OF PROVIDER OR SUPPLIER HAMILTON TRACE OF FISHERS	STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037
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K 000 Bldg. 01	<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: 03/18/15</p> <p>Facility Number: 012644 Provider Number: 155793 AIM Number: 201046710</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hamilton Trace of Fishers was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2.</p> <p>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, spaces open to the corridors and hard wired smoke detectors in all resident sleeping rooms. The facility has</p>	K 000	<p>April 3, 2015 Kim Rhoades, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Dear Ms. Rhoades: Please find enclosed the Plan of Correction to the annual Life Safety Code Survey conducted on March 18, 2015. This letter is to inform you that the plan of correction attached is to serve as Hamilton Trace's credible allegation of compliance. We allege compliance on April 3, 2015. We are requesting a desk review for this plan of correction. If you have any further questions, please do not hesitate to contact me at (317) 813-4444.</p> <p>Sincerely, Melissa Hampton, HFA Administrator</p> <p>Submission of this plan of correction in no way constitutes an admission by Hamilton Trace of Fishers or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care other services provided in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. Hamilton Trace of Fishers reserves the right to challenge in legal</p>	
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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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K 036 SS=E Bldg. 01	<p>a capacity of 108 and had a census of 104 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered except for one detached garage used for facility storage which was not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/25/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Travel distance (exit access) to exits is in accordance with 7.6. 18.2.6 Based on observation and interview, the facility failed to ensure 1 of 12 smoke compartments were provided with a remote exit which did not exceed 150 feet from a resident room corridor door. LSC at 18.2.6.2.1 requires the travel distance between any room door used as an exit access and an exit shall not exceed 150 ft. This deficient practice affects 22 residents on Companion unit as well as staff and visitors.</p> <p>Finding include:</p>	K 036	<p>proceedings, all deficiencies, statements, findings, facts, and conclusions that form the basis of the deficiency. This plan of correction serves as the allegation of compliance by April 3, 2015. This statement of deficiencies and plan of correction will be reviewed at the May Quality Assurance/Assessment Committee meeting.</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Reviewed architectural renderings and visually verified that areas cited have a 1 hour fire resistive smoke barrier wall that extends tight to the underside of the roof sheathing above, which meet K36 standards. Area cited is between fire resistive smoke barrier walls is 161 feet and 162 feet which meets K36 standards of 200 feet and has a full sprinkler system.</p>	04/03/2015	

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K 038 SS=E Bldg. 01	<p>Based on observation on 3/18/15 at 2:00 p.m. with the Maintenance Supervisor, the north exit access for the residents on the Companion unit to the next nearest exit which was the Skilled exit west was measured by facility staff to be 325 feet. Based on interview concurrent with the observation with the Maintenance Supervisor it was acknowledged the north exit access to the Skilled exit west exceeded 150 feet.</p> <p>3.1-19(b)</p> <p>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. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 12 exit doors with electromagnetic locks unlocked while the fire alarm system was activated. LSC 7.2.1.6.2(e) requires doors with special locking arrangements such as electromagnetic locks shall automatically</p>	K 038	<p>(See Attachment A) II. The facility will identify other residents that may potentially be affected by the deficient practice. All residents on the 800 hall have the potential to be affected. III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Travel distance between any room door used as an exit access and an exit will not exceed 200 feet within a full sprinkler facility. IV The facility will monitor the corrective action by implementing the following measures. Results of the observation will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. V. Plan of Correction completion date. Plan of Completion date is April 3, 2015.</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. The electromagnetic lock on the front door has been adjusted to open during a fire alarm. (Attachment B) II.</p>	04/03/2015	

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K 143 SS=E Bldg. 01	<p>unlock upon actuation of an approved fire alarm system and remain unlock until the system is reset. This deficient practice could affect at least 24 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 03/18/15 during a fire alarm test at 3:47 p.m. with the Maintenance Supervisor the electromagnetic lock on the front door unlocked, but when approached with a wander guard device the electromagnetic lock reactivated preventing residents from the skilled and rehabilitation units from exiting. Based on interview on 03/18/15 concurrent with the observation it was acknowledged by the Maintenance Supervisor the exit door would not unlock when approached with a wander guard device.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(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;</p>		<p>The facility will identify other residents that may potentially be affected by the deficient practice. All residents with a wander guard have the potential to be affected. III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. During monthly fire alarm checks the Maintenance Director or designee will monitor the front door and wander guard system to ensure they open during the alarm. IV. The facility will monitor the corrective action by implementing the following measures. Maintenance Director or designee will complete visual observation of front door to ensure they open without failure. Preventative maintenance will be completed as necessary. Results of the monthly observation will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. V. Plan of Correction completion date. Plan of Completion date is April 3, 2015.</p>				

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	<p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(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</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 oxygen storage rooms where oxygen transfer occurs had continuously working, electrically powered mechanical ventilation. This deficient practice could affect 24 residents on skilled and rehabilitation units as well as visitors and staff in the area.</p> <p>Findings include:</p> <p>Based on observation on 03/18/15 during the tour between 1:06 p.m. to 2:00 p.m. with the Maintenance Supervisor, the oxygen storage rooms behind the nursing station on the skilled and rehabilitation units which were used to store and transfer oxygen was not provided with electrically powered vents. Based on interview on 03/18/15 at 2:10 p.m. it was acknowledged by the Maintenance Supervisor these rooms were used to transfer oxygen and was unaware the vents were not electrically powered.</p>	K 143	<p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. The oxygen storage room vents have been repaired. (Attachment C)</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice. All residents have the potential to be affected.</p> <p>III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. During monthly preventative maintenance checks the Maintenance Director or designee will monitor vents in oxygen storage rooms for proper function.</p> <p>IV The facility will monitor the corrective action by implementing the following measures. Maintenance Director or designee will complete visual observation of vents in oxygen storage rooms for proper function. Preventative maintenance will be completed as</p>	04/03/2015			

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	3.1-19(b)		necessary. Results of the monthly observation will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. V. Plan of Correction completion date. Plan of Completion date is April 3, 2015 .		