

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155298	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/08/2014
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NAME OF PROVIDER OR SUPPLIER  PYRAMID POINT POST-ACUTE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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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: 04/08/14</p> <p>Facility Number: 000195 Provider Number: 155298 AIM Number: 100267690</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Pyramid Point Post-Acute Rehabilitation 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 three story facility was determined to be of Type II (222) 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 battery operated</p>	K010000	<p>This Plan of Correction is the center's credible allegation of compliance. <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></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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	<p>smoke detectors in all resident sleeping rooms. The facility has a capacity of 135 and had a census of 75 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/10/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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</p> <p>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 70 of 70 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <p>(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</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Disaster Procedure: Fire Emergency" documentation with the Maintenance Supervisor during record review from 9:30 a.m. to 11:15 a.m. on 04/08/14, the facility's written fire safety plan did not include staff response to the</p>	K010048	<p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</b> No residents were directly affected by the alleged deficient practice, but all residents have the potential to be affected.</p> <p><b>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?</b> No residents were directly affected by the alleged deficient practice, but all residents have the potential to be affected. The facility has reviewed and revised the fire safety plan to include the expected staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms. The facility has reviewed and revised the fire safety plan to address the use of the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. <b>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur?</b> After the fire safety plan was revised, staff were</p>	05/08/2014			

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	<p>activation of battery operated smoke detectors installed in resident sleeping rooms. Based on observations with the Maintenance Supervisor during a tour of the facility from 11:15 a.m. to 12:15 p.m. and 1:00 p.m. to 3:00 p.m. on 04/08/14, battery operated smoke detectors are installed in each resident sleeping room. Based on interview at the time of record review, the Maintenance Supervisor 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> <p>2. 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:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for</li> </ol>		<p>re-educated regarding the proper response to the activation of battery operated smoke detectors installed in resident sleeping rooms. The kitchen staff were re-educated to activate the overhead hood extinguishing system to suppress a fire before using the K-class fire extinguisher. The updated fire safety plan is attached to this response for review. <b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</b> As an indication of the staff's understanding of these revisions, management will randomly interview 5 staff weekly. These interviews will be conducted at least once weekly for four weeks, then monthly thereafter unless identified as requiring adjustment through the QA process.</p>				

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	<p>evacuation (8) Extinguishment of fire This deficient practice could affect five kitchen staff.</p> <p>Findings include:</p> <p>Based on review of "Disaster Procedure: Fire Emergency" documentation with the Maintenance Supervisor during record review from 9:30 a.m. to 11:15 a.m. on 04/08/14, the fire disaster plan 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. Based on observation with the Maintenance Supervisor during a tour of the facility from 11:15 a.m. to 12:15 p.m. on 04/08/14, a K-class fire extinguisher was located in the kitchen. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using the K-class fire extinguisher.</p> <p>3.1-19(a)</p>				

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K010052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review, observation and interview; the facility failed to ensure 2 of 2 duct detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p>	K010052	<p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>No residents were directly affected by the alleged deficient practice, but all residents have the potential to be affected.</p> <p><b>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?</b></p> <p>No residents were directly affected by the alleged deficient practice, but all residents have the potential to be affected. In order to prevent the issue from affecting any residents, the facility has replaced both of the 2 duct detectors identified as being allegedly deficient.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that</b></p>	05/08/2014			

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	<p>(1) Calibrated test method</p> <p>(2) Manufacturer's calibrated sensitivity test instrument</p> <p>(3) Listed control equipment arranged for the purpose</p> <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</p> <p>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of SafeCare "Sensitivity Test and Inspection" documentation dated 02/19/14 with the Maintenance Supervisor during record review from 9:30 a.m. to 11:15 a.m. on 04/08/14, each of two duct detectors were not listed as being sensitivity tested. The aforementioned sensitivity test report stated the "DD N. Mech. Rm" and the "DD S. Mech Rm." passed functional testing and listed a sensitivity range of 0.9 to 1.90 for each detector but did not state the results of sensitivity testing for</p>		<p><b>deficient practices do not recur?</b></p> <p>The 2 duct detectors that were replaced will be routinely tested as per regulation.</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</b></p> <p>The 2 duct detectors that were replaced will be routinely tested as per regulation. The contracted service responsible for testing the duct detectors will be notified and will submit reports upon completion to identify any sensitivity issues.</p>				

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	<p>each duct detector. Based on interview at the time of record review, the Maintenance Supervisor stated no additional duct detector sensitivity testing documentation was available for review and acknowledged duct detector sensitivity testing documentation within the most recent two year period was not available for review. Based on observations with the Maintenance Supervisor during a tour of the facility from 11:15 a.m. to 12:15 p.m. on 04/08/14, a duct detector hard wired to the fire alarm system was installed at the air handling equipment in the north and south mechanical rooms.</p> <p>3.1-19(b)</p>			
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K010160 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observation and interview, the facility failed to ensure the elevator equipment in 1 of 1 elevator equipment rooms was provided with a shunt trip. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon, or prior to, the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect four residents, staff and visitors in the facility elevators if the sprinkler system was activated in the elevator machine room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 11:15 a.m. to 12:15 p.m. on 04/08/14, the elevator machine room was provided with automatic sprinklers and no evidence of shunt trip installation was noted. Based on interview at the time of observation, the Maintenance</p>	K010160	<p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>No residents were directly affected by the alleged deficient practice, but all residents have the potential to be affected.</p> <p><b>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?</b></p> <p>No residents were directly affected by the alleged deficient practice, but all residents have the potential to be affected.</p> <p>Once the facility became aware of this new regulation, the facility immediately contracted an electrician to install a shunt trip to the elevators as specified in the regulation.</p> <p><b>What measures will be put into</b></p>	05/08/2014			

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	<p>Supervisor acknowledged comprehensive care residents have customary access to the elevators and acknowledged the aforementioned elevator machine room was not provided with a shunt trip.</p> <p>3.1-19(b)</p>		<p><b>place or what systemic changes will be made to ensure that deficient practices do not recur?</b></p> <p>After the installation of the shunt trips, we will be in full compliance.</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</b></p> <p>After the installation of the shunt trips, we will be in full compliance and no further monitoring will be necessary.</p>	