

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155717	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/16/2015
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NAME OF PROVIDER OR SUPPLIER  ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN 46222
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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: 02/16/15</p> <p>Facility Number: 000376 Provider Number: 155717 AIM Number: 100275510</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, the Alpha Home Association of Greater Indianapolis, Inc. was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type 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</p>	K 000	Preparation and/or Execution of this plan of correction in general or this corrective action plan in particular, does constitute an admission of agreement by the alpha Home of the facts all edged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective action plans are prepared and/or executed in compliance with state and federal laws.	
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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 018 SS=E Bldg. 01	<p>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 a census of 28 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one detached storage shed.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 02/20/15.</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 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ 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</p> <p>Roller latches are prohibited by CMS</p>			

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	<p>regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure 2 of over 75 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 16 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Housekeeping Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 02/16/15, the corridor door to the 400 Hall Linen Room and the corridor door to the former soiled utility room by the 200 Hall entrance each had the door handle and latching mechanism removed which prevented each door from closing and latching into the door frame. In addition, two one inch diameter holes were noted in each door where the door handle was formerly located which would not resist the passage of smoke. Based on interview at the time of the observations, the Housekeeping Supervisor acknowledged each of the aforementioned corridor doors had an impediment to closing, latching and would not resist the passage of smoke.</p> <p>3.1-19(b)</p>	K 018	<p>K 018 It is the policy of this facility to ensure doors haveno impediment for closing with a means suitable for keeping smoke from passingthrough and keeping the door closed.</p> <p>Purchase order signed,deposit received by locksmith. Hardware has been ordered for 400 hallway linenroom and 200 hallway entrance doors. Installation will be provided by locksmithupon delivery. The facility doors shall be place on the monthly QualityAssurance review for monitoring and compliance. The monitoring of the door andlocks placed on the checklist for the Maintenance Director. The QualityAssurance Team to oversee monitoring for compliance. Results of the monitoring will be reviewed during thefacility's Quality Assurance meeting for compliance monitoring will be ongoing.</p>	03/18/2015	

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K 029 SS=E Bldg. 01	<p>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</p> <p>Based on observation and interview, the facility failed to ensure 2 of 7 hazardous areas such as combustibile storage rooms greater than 50 square feet in size were separated from other areas by self closing doors. Doors to hazardous areas are self closing or close automatically upon activation of the fire alarm system. This deficient practice could affect 14 residents, staff and visitors if needing to exit the facility from the 100 Hall.</p> <p>Findings include:</p> <p>Based on observations with the Housekeeping Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 02/16/15, Room 101 and Room 109 in the 100 Hall each measured greater than 50 square feet in size and were being utilized to store additional</p>	K 029	<p>K 029 It is the policy of the this facility, rooms that measure more than 50 feet remain self-closing and/or close automatically upon activation of the fire alarm system. The rooms measuring more than 50 feet on the 100 hallway shall be equipped with a self-closing device. The locksmith to provide installation. The purchase order signed awaiting delivery of the hardware. All fire drill is completed in accordance with the fire drillschedule. Monthly drills complemented by the maintenance director. The maintenancedirector retains all drills in a three ring binder. Each month the QualityAssurance Committee will review the drills for compliance and</p>	03/18/2015			

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K 050 SS=F Bldg. 01	<p>mattresses, furniture and clothing in trash bags. The corridor entry door to each room was not equipped with a self closing device. Based on interview at the time of the observations, the Housekeeping Supervisor stated each of the aforementioned rooms was being utilized as a storage room and acknowledged the entry door to each room which measured greater than fifty square feet was not equipped with a self closing device.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly</p>		<p>monitoring on the drills are completed.</p> <p>The 2015 fire drill calendar completed, the maintenance has been placed in the three ring binders and copy to Quality Assurance. The fire drill shall be placed on the monthly Quality Assurance review for monitoring and compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting for compliance monitoring will be ongoing. Results of the monitoring reviewed during the facility's Quality Assurance meeting. This review to occur for the next six months monitoring will be ongoing. The Maintenance Director monitoring the doors monthly for compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting for compliance monitoring will be ongoing.</p>		

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	<p>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</p> <p>Based on record review and interview, the facility failed to document fire drills conducted on the second shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Housekeeping Supervisor during record review from 12:10 p.m. to 12:30 p.m. on 02/16/15, documentation of a fire drill conducted on the second shift in the fourth quarter of 2014 was not available for review. Based on interview at the time of record review, the Housekeeping Supervisor acknowledged documentation of a fire drill conducted on the second shift in the fourth quarter of 2014 was not available for review.</p> <p>3.1-19(b)</p>	K 050	<p>K 050 It is the policy of the Alpha Home to have competent leadership planning and conducting fire drills with staff in the accordance NFPA 101. All fire drill is completed in accordance with the fire drills schedule. Monthly drills complemented by the maintenance director. The maintenance director retains all drills in a three ring binder. Each month the Quality Assurance Committee will review the drills for compliance and monitoring on the drills are completed. The 2015 fire drill calendar completed, the maintenance has been placed in the three ring binders and copy to Quality Assurance The fire drill shall be place on the monthly Quality Assurance review for monitoring and compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting for compliance monitoring will be ongoing. Results of the monitoring reviewed during the facilities Quality Assurance meeting. This review to occur for the next six months monitoring</p>	03/18/2015

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K 052 SS=F Bldg. 01	<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>1. Based on record review, observation and interview; the facility failed to maintain the operational integrity of 1 of 1 fire alarm systems in accordance with NFPA 72, 1999 Edition, National Fire Alarm Code. LSC 9.6.1.7 states, to ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electric Code and NFPA 72. NFPA 72, 7-5.2.2 requires a permanent record of all inspections, testing and maintenance which includes the disposition of problems identified during the test such as the problem has been corrected or has been successfully retested. This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:  Based on record review with the Housekeeping Supervisor from 12:10</p>	K 052	<p>willbe on going.</p> <p>K – 52 It is the policy of the facility to ensure and providea permanent record of the annual fire alarm inspection with documentation forreview. The annual fire system was completed on 01/02/1015. Each time the fire inspector’s contractorthe invoice has stated the system has been serviced tested and re inspectedwith the total system fully operational. Training provided the facility staff with the auxiliarydrains drain instruction with the sprinkler system. Larger compressor installedfor sprinkler system. Documented smoke detector test and repairs submitted, Completedby safe care in January 2015. The documented written</p>	03/18/2015

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	<p>p.m. to 12:30 p.m. on 02/16/15, documentation of fire alarm system testing within the most recent twelve month period was not available for review. Based on observation with the Housekeeping Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 02/16/15, the fire alarm panel located in the main lobby at the front of the building was in trouble mode. Based on interview at the time of the observation, the Housekeeping Supervisor stated the fire alarm system has been in trouble mode for the last couple of days because of a sprinkler system water leak. The Housekeeping Supervisor stated documentation of the type of system repair needed and the status and timetable for repair was not available for review and acknowledged the fire alarm panel located in the main lobby at the front of the building had been in trouble mode for the last couple of days.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to document annual testing of the facility fire alarm system. NFPA 72, 7-3.2 refers to fire alarm component testing frequencies in Table 7-3.2 which requires an annual fire alarm system test. Section 7-5.2 requires a</p>		<p>record is kept in the administrator office and copies in the maintenance director's office. The administrator or designee will monitor inspections to ensure they are conducted at the proper intervals and documentation maintained. The administrator will review the facility preventative maintenance binder each month to ensure appropriate testing is completed. Any negative findings will be reviewed by the interdisciplinary team and a plan of action implemented to resolve the concern. Quality Assurance to monitor for compliance for the next six months for continued compliance.</p>	

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	<p>permanent record of all inspections, testing and maintenance shall be provided that includes information requested in Figure 7-5.2.2. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Housekeeping Supervisor from 12:10 p.m. to 12:30 p.m. on 02/16/15, documentation of annual testing of the fire alarm system was not available for review. Based on interview at the time of record review, the Housekeeping Supervisor acknowledged documentation of fire alarm system inspection within the last twelve months was not available for review.</p> <p>3-1.19(b)</p> <p>3. Based on record review, observation and interview; the facility failed to ensure all smoke 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 that the detector has</p>			

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	<p>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 that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method</li> <li>(2) Manufacturer's calibrated sensitivity test instrument</li> <li>(3) Listed control equipment arranged for the purpose</li> <li>(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</li> <li>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</li> </ol> <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</p>			

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K 062 SS=F Bldg. 01	<p>affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Housekeeping Supervisor from 12:10 p.m. to 12:30 p.m. on 02/16/15, smoke detector sensitivity testing documentation for the most recent two year period was not available for review. Based on interview at the time of record review, the Housekeeping Supervisor acknowledged documentation of smoke detector sensitivity testing in the last two years was not available for review.</p> <p>Based on observations with the Housekeeping Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 02/16/15, smoke detectors hard wired to the fire alarm system were observed installed in the corridors and in all resident sleeping rooms.</p> <p>3.1-19(b)</p> <p>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</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously</p>	K 062	K – 062 Temporary waiver request for an extension of time for deficiency #2 to	03/18/2015

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	<p>maintained in reliable operating condition. LSC Section 9.7.5 states 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, Section 1-4.4 states the owner or occupant promptly shall correct or repair deficiencies, damaged parts, or impairments found while performing the inspection, test, and maintenance requirements of this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. Exception: Where an occupant, management firm, or managing individual has received the authority for inspection, testing, and maintenance in accordance with the Exception to 1-4.2, the occupant, management firm, or managing individual shall comply with 1-4.4. This deficient practice would directly affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Housekeeping Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 02/16/15, each of four automatic sprinkler system gauges at the system</p>		<p>perform the sprinkler system flush has been submitted to CMS. The start date was 12/06/2014 and the end date is 05/01/2015. It is the facility policy to ensure the facility sprinkler systemis continuously maintained in reliable operating condition and are inspectedand tested periodically. Circle City Fire Protection completes the quarterlyinspection of the fire sprinkler, no issues noted at the time. Circle City Fire Protection is scheduled to complete theflush in April 2015. Due to the risk of the pipes freezing the flushing has tobe completed with temperatures remaining constantly above freezing to avoid thepossibility of damage that could occur if piping became frozen. Written records of the inspection and tests shall be kept inthe preventive maintenance binder for review. The administrator or designee will monitor</p>	

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	<p>riser had pressure gauge readings of zero. Based on interview at the time of the observations, the Housekeeping Supervisor stated the automatic sprinkler system had been placed out of service for the last couple of days because of a sprinkler system water leak. The Housekeeping Supervisor stated documentation of the type of system repair needed and the status and timetable for repair was not available for review and acknowledged the automatic sprinkler system was not operable due to a water leak.</p> <p>3.1-19(b)</p> <p>2. 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</p>		<p>inspections to ensure they are conducted at the proper intervals and documentation maintained. Results of the monitoring reviewed during the facilities Quality Assurance meeting. This review to occur for the next six months monitoring will be on going.</p>	

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	<p>practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Housekeeping Supervisor from 12:10 p.m. to 12:30 p.m. on 02/16/15, 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 interview at the time of observation, Housekeeping Supervisor acknowledged 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.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of over 100 sprinkler heads was 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.</p> <p>Findings include:</p>			

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K 072 SS=E Bldg. 01	<p>Based on observation with the Housekeeping Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 02/16/15, the automatic sprinkler located in the storage room in the Housekeeping Supervisor's had a missing escutcheon. Based on interview at the time of the observation, the Housekeeping Supervisor acknowledged the aforementioned automatic sprinkler had a missing escutcheon.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>Based on observation and interview, the facility failed to ensure 3 of 7 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 16 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Housekeeping Supervisor during a tour</p>	K 072	<p>K - 072 It is the policy of this facility to ensure the meansof egress is maintained free of obstructions or impediments to in case of fireor other emergency. The 100 hallway the chest the resident beds and housekeepingcart has been removed. The 200 hallway walkways</p>	03/18/2015

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K 074 SS=C Bldg. 01	<p>of the facility from 12:30 p.m. to 2:00 p.m. on 02/16/15, the following was noted:</p> <p>a. three resident beds, a chest of drawers and a housekeeping cart were unattended and were being stored in the 100 Hall corridor.</p> <p>b. the 200 Hall exit discharge by Room 217 to the rear parking lot was completely obstructed by a pile of brush and was impassable. In addition, a garden hose was laid across the exit path at the aforementioned exit discharge outside the exit door.</p> <p>c. an automobile was parked outside the facility in the path of egress for the facility exit by Room 102.</p> <p>Based on interview at the time of the observations, the Housekeeping Supervisor acknowledged the aforementioned means of egress were not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are</p>		<p>cleared and the extension hoseremoved.</p> <p>New no parking sign placed on the property and the tow companycontract signed for any car violators to be removed.</p> <p>Written records of the inspection and tests shall be keptwith maintenance with a copy submitted the Quality assurance committee forreview.</p> <p>The administrator will review the facility preventative maintenancebinder each month to ensure copies are kept.</p> <p>Results of the monitoring will be reviewed during thefacility's Quality Assurance meeting for compliance, monitoring will continuefor next 6 months.</p>	

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	<p>in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on record review, observation and interview; the facility failed to ensure cubicle curtains in 3 of 4 smoke compartments were flame resistant. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Housekeeping Supervisor from 12:10 p.m. to 12:30 p.m. on 02/16/15, documentation of cubicle curtain flame resistance documentation was not available for review. Based on observations with the Housekeeping Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 02/16/15, cubicle curtains were installed in each of three smoke compartments where resident sleeping rooms were located and each cubicle curtain observed</p>	K 074	Request for IDR The facility has submitted the vendor produced AFFIDAVIT OF FLAMEPROOFING.The certificates states that the above fabric is inherently flame resistant for the life of the fabric.without requiring futher treatment to insure its flame resistant.Therefore the Alpha Home is requesting that this tag be removed with the vendor document affidavit of flameproofing.K – 074 It is the policy to provide the vendors specifications on the curtains flame retardant material with the documentation provided with the products. The facility provided copies of the cubicle curtains which states fabric is inherently flame resistance for the life of the fabric. Documented affidavit of flame proofing keep with maintainedirector and copy provided with the Quality Assurance committee. The	03/18/2015

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K 144 SS=C Bldg. 01	<p>had no affixed documentation stating it was inherently flame retardant. Based on interview at the time of record review and of the observations, the Housekeeping Supervisor was unaware if cubicle curtains had been treated with a flame retardant material and acknowledged documentation for flame retardant material treatment and cubicle curtain flame resistance documentation was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. In addition, NFPA 101 at Section 4.6.12.1 requires that any device, equipment or system required for compliance with this Code shall be continuously maintained. This deficient practice could affect all residents, staff</p>	K 144	<p>administrator will review the facility preventativemaintenance binder each month to ensure appropriate testing is completed. Anynegative findings will be reviewed by the interdisciplinary team and a plan ofaction implemented to resolve the concern Results of the monitoring reviewed during the facilitiesQuality Assurance meeting. This review to occur for the next six months monitoring willbe on going. The Quality Assurance Committee will be responsible forfacility compliance and will review monthly, on an ongoing basis.</p> <p>K – 144 It is the policy of this facility to annually testthe emergency generator and provide a written record of the starting batterydocumentation for 52 weeks. Buckeye Maintenance out to service the auxiliary faulttrouble on the panel. The facility generator continues to transfer power whenthe generator is needed. The facility</p>	03/18/2015

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	<p>and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Housekeeping Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 02/16/15, the annunciator panel at the nurses ' station for the emergency generator indicated an "auxiliary fault" trouble light was activated. Building power was transferred to the emergency generator when a manual start was performed at 1:25 p.m. Based on interview at the time of observation, the Housekeeping Supervisor stated the facility has one emergency generator to supply the facility with emergency power, the auxiliary fault trouble has been indicating a trouble signal for about one week and acknowledged no repair documentation was available for review to indicate the status of repair to ensure the emergency generator was being continuously maintained.</p> <p>3.1-19(b)</p> <p>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 52 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99</p>		<p>replaced the batteries no trouble noted on panel. Documented record review provided for each service ticket with the generator contractor. Written records of the inspections test and replacement batteries shall be kept in the preventative maintenance binder for review. The administrator or designee will review the facility preventative maintenance binder each month to ensure appropriate testing is completed. Any negative findings will be reviewed by the interdisciplinary team and a plan of action will be implemented to resolve the concern. Results of the monitoring reviewed during the facilities Quality Assurance meeting. This review to occur for the next six months monitoring will be on going. The Quality Assurance Committee will be responsible for facility compliance and will review</p>	

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	<p>requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of 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.</p> <p>Findings include:</p> <p>Based on record review with the Housekeeping Supervisor from 12:10 p.m. to 12:30 p.m. on 02/16/15, documentation of weekly inspections of the starting batteries for the emergency generator for the most recent 52 week period was not available for review. Based on interview at the time of record review, the Housekeeping Supervisor acknowledged documentation of weekly inspections of the starting batteries for the emergency generator for the most</p>		monthly, on an ongoing basis.	

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K 154 SS=F Bldg. 01	<p>recent 52 week period was not available for review.</p> <p>3.1-19(b)</p> <p>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</p> <p>1. Based on observation and interview, the facility failed to evacuate the building or conduct a fire watch in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Housekeeping Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 02/16/15, each of four automatic sprinkler system gauges at the system riser had pressure gauge readings of zero. Based on interview at the time of the observations, the Housekeeping</p>	K 154	<p>K – 154 It is the policy of the facility to provide a firewatch if the automatic sprinkler system is placed out of service for four hours or more. The fire alarm system will show trouble and the panel box will show low pressure however the system is operable and the system resets itself for trouble when the compressor stabilizes the air pressure. Staff in serviced on the fire watches policy the system is set up to notify the facility administrator with there is trouble identified with the system. The fire panel box will notify</p>	03/18/2015

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	<p>Supervisor stated the automatic sprinkler system had been placed out of service for the last couple of days because of a sprinkler system water leak and answered no when questioned if a fire watch had been instituted with the proper authorities having jurisdiction being notified.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed in the event the automatic 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.</p> <p>Findings include:</p> <p>Based on record review with the Housekeeping Supervisor from 12:10 p.m. to 12:30 p.m. on 02/16/15, a written fire watch policy in the event the</p>		<p>the director of any troubleand re notify in the event of the system resetting itself.</p> <p>Fire Watch policy posted and fire Watch policy in servicedwith staff. Posted instructions board provides instructions on notification ofthe proper authorities, and sprinkler system protocol.</p> <p>Contractors will come out inspect the alarm and providerepair to the system with inspection and resetting the panel box.</p> <p>The documented written record is kept in the administrator office and copies in themaintenance director's office.</p> <p>The administrator or designee will monitor inspections toensure they are conducted at the proper intervals and documentation maintained.</p> <p>The administrator will review the facility preventativemaintenance binder each month to ensure appropriate testing is completed. Anynegative findings will be reviewed by</p>	

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K 155 SS=C Bldg. 01	<p>automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period was not available for review. Based on interview at the time of record review, the Housekeeping Supervisor acknowledged a 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 available for review.</p> <p>3.1-19(b)</p> <p>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</p> <p>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.</p>	K 155	<p>the interdisciplinary team and a plan of action implemented to resolve the concern</p> <p>The Quality Assurance Committee will be responsible for facility compliance and will review monthly, on an ongoing basis.</p> <p>K- 155 It is the policy of the facility to provide a firewatch in the event of the fire alarm being unoperable for 4 hours or more in a twenty four period. The fire alarm system fully operation able. Safe care inspectors inspected the fire alarm panel tested it</p>	03/18/2015

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	<p>Findings include:</p> <p>Based on record review with the Housekeeping Supervisor from 12:10 p.m. to 12:30 p.m. on 02/16/15, a 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 available for review. Based on interview at the time of record review, the Housekeeping Supervisor acknowledged a 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 available for review.</p> <p>3.1-19(b)</p>		<p>and found no trouble. Fire Watch policy posted and fire Watch policy in servicedwith staff. Posted instructions board provides instructions on notification ofthe proper authorities, and sprinkler system protocol. The system is set up to notify the facility administratorwith there is trouble identified with the system. Written invoices,purchase orders, and inspection reports to be kept by maintenance director. Copy of the inspection reports provided toadministrator and submitted to the quality assurance committee. The administrator or designee will monitor inspections toensure they are conducted at the proper intervals and documentation maintained. The administrator will review the facility preventativemaintenance binder each month to ensure appropriate testing is completed. Anynegative</p>	

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			<p>findings will be reviewed by the interdisciplinary team and a plan of action implemented to resolve the concern.</p> <p>Results of the monitoring reviewed during the facilities Quality Assurance meeting.</p> <p>This review to occur for the next six months monitoring will be on going.</p> <p>The Quality Assurance Committee will be responsible for facility compliance and will review monthly, on an ongoing basis.</p>	