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
	155786		08/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/24/15 Facility Number: 012466 Provider Number: 155786 AIM Number: 201014060 At this Life Safety Code survey, Allisonville Meadows 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 18, New Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was 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 rooms. The facility has a capacity of 171 and had a census of 137 at the time of this survey.	K 0000	The creation and submission of the Plan Of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation or regulation. This provider respectfully request that the 2567 plan of Correction be considered the letter of credible allegation of compliance, and requests a desk review in lieu of post survey review on or after September 23, 2015.	

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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	All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.			
K 0039 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes is at least 8 feet. In limited care facilities and psychiatric hospitals, width of aisles or corridors is at least 6 feet. 18.2.3.3, 18.2.3.4 Based on observation, interview and record review; the facility failed to ensure the width of corridors were at least eight feet wide for 1 of 6 corridors. This deficient practice could affect 16 residents on 400 hall as well as visitors and staff using the service hall exit during an emergency evacuation. Findings include: Based on observation on 08/24/15 at 2:15 p.m. with the Maintenance Supervisor there were two dirty dish carts, two food carts, three chairs and fifteen cardboard boxes against the corridor wall limiting the exit corridor width to five feet. Based on interview on 08/24/15 concurrent with the observation with the Maintenance Supervisor it was acknowledged the aforementioned items were regularly stored in the Service corridor and would	K 0039	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The two dish carts, two food carts, three chairs, and the fifteen cardboard boxes were removed from the corridor.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will betaken?**All 400 hall residents, staff and visitors have the potential to be affected. The Maintenance Director removed the obstruction or impediments on the service hallway to allow for eight feet wide corridors.**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?The Maintenance Director will check the corridor**	09/22/2015

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	not allow an eight foot clear width to exit through. Based on record review on 08/24/15 at 3:05 p.m. with the Maintenance Supervisor the facility floor plan verified the Service corridor as the secondary evacuation route for the residents on 400 hall which was undisputed by the Maintenance Supervisor. 3.1-19(b)		**on a weekly basis to ensure it is free from obstruction and or impediments.. How will the corrective action be monitored to ensure the deficient practice will not occur?** .Maintenace director will complete a Life Safety CQI and report findings to the CQI meetings held on a monthly basis, to ensure corridors are free from obstruction and or impediments. this CQI will be completed monthly x 6 and quartely thereafter for one year. the findings will be given to the Executive director, and an action plan will be developed if not 100%.	
K 0066 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied			

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	are readily available to all areas where smoking is permitted. 18.7.4 Based on observation and interview, the facility failed to ensure 1 of 1 smoking policies was adhered to in that smoking is only permitted in staff vehicles. This deficient practice could affect at least 16 resident exiting out of 400 hall, including visitors and staff if they are utilizing the Service hall exit during a fire emergency. Findings include: Based on observation on 08/24/15 at 2:17 p.m. with the Maintenance Supervisor, smoking is restricted to employee vehicles only and staff was observed smoking outside the 400 service hall exit. Next to the exit discharge were observed sixty extinguished cigarette butts thrown into the mulch next to the building and not in a non combustible container. Based on interview on 08/24/15 at 2:21 p.m. the Maintenance Supervisor acknowledged one staff member was observed smoking outside the 400 service hall exit and not in their vehicle as the smoking policy directed. 3.1-19(b)	K 0066	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Maintenance director removed all the cigarette butts from the area outside of the service hall door and all staff were given the smokingpolicy and the smoking policy is posted by the time clock to remind staff that smoke, must do so in there cars.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will betaken? All residents residing on the 400 hall, along with visitors and staff have the potential to be affected. the smoking policy was given to all staff and posted by the time clock. Any staff member violating this policy will receive disciplinary action up to and including termination.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Director will monitor the mulch bed for any discarded cigarette butts and if necessary will review the camera on the outside of the service hallway to find out who is violating this policy and disciplinary action**	09/22/2015

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			will be taken up to and including termination for those found violating the smoking policy.How will the corrective action be monitored to ensure the deficient practice will not occur? The Maintenance Director will complete a Life Safety CQI weekly and report it's findings to the CQI committee on a monthly basis. This will be done weekly x4, monthly x 6 and quartely thereafter for one year. The executive Director will be made aware of findings and appropriate disciplinary action will be taken for those who violate the smoking policy.	