

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 11/09/2015
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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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K 0000 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: 11/09/15</p> <p>Facility Number: 000195 Provider Number: 155298 AIM Number: 100267690</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 smoke detectors in all resident sleeping rooms. The facility has a</p>	K 0000		

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 0018 SS=D Bldg. 01	<p>capacity of 135 and had a census of 37 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 completed -11/13/15-DA</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 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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 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 5 staff and visitors in the service</p>	K 0018	<p>K018</p> <ol style="list-style-type: none"> 1.The positive latching mechanism was replaced on11-10-15. 2.No residents were affected. 3.The latching mechanism will be added to the preventative maintenance log. 4.Any missing latches will be repaired immediately. Any missing 	11/27/2015

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	<p>hall by the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations and the Van Driver during a tour of the facility from 11:30 a.m. to 1:50 p.m. on 11/09/15, the positive latching mechanism was removed from the south corridor door in the service hall to the kitchen which provided an impediment to closing and latching the door into the door frame. Based on interview at the time of observation, the Director of Plant Operations acknowledged the aforementioned corridor door had an impediment to closing and latching into the door frame.</p> <p>3.1-19(b)</p>		<p>latches will be reported to the QA committee meeting monthly by the Maintenance director, on going.</p>	

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K 0025 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure openings through 1 of 22 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 5 staff and visitors in the vicinity of the first floor smoke barrier wall by the Laundry.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations and the Van Driver during a tour of the facility from 11:30 a.m. to 1:50 p.m. on 11/09/15, the six</p>	K 0025	<p>K025</p> <p>1.The opening in the smoke barrier was repaired on11-12-15. The opening was made by acontractor repairing a water line.</p> <p>2.No residents were affected</p> <p>3.Any time a contractor does work to a smokebarrier the maintenance director will visualize the opening for completeness.If any openings are found they will be sealed up immediately.</p> <p>4.Maintenance will report monthly to the QACommittee any contractor work and results of his inspection. On going</p>	11/27/2015			

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K 0034 SS=E Bldg. 01	<p>inch annular space surrounding a three inch in diameter pipe which passed through the smoke barrier wall above the suspended ceiling above corridor door set by the Laundry was not filled with a material to maintain the smoke resistance of the smoke barrier. Based on interview at the time of observation, the Director of Plant Operations acknowledged the aforementioned opening in the first floor smoke barrier wall by the Laundry did not maintain the fire resistance rating of the smoke barrier wall.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 Based on observation and interview, the facility failed to ensure items stored in 1 of 4 interior fire escape stairways would not interfere with egress. LSC 7.2.2.5.3 requires usable space within an exit enclosure, including under stairs, or any</p>	K 0034	<p>K034</p> <ol style="list-style-type: none"> 1.All items were removed from the north stairwell. 2.No residents were affected. 3.Stairwell observation will be added to the preventative maintenance log, to ensure nothing being stored in the 	11/27/2015

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K 0038 SS=F Bldg. 01	<p>open space within the enclosure shall not be used for any other purpose which could interfere with egress. This deficient practice could affect 26 residents, staff and visitors using the north exit stairwell on the first floor for evacuation.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations and the Van Driver during a tour of the facility from 11:30 a.m. to 1:50 p.m. on 11/09/15, the north stairwell on the first floor which was marked as a first floor exit was used to store four chandeliers, ten light fixtures and an eight foot long by three foot wide Formica countertop. Based on interview at the time of observation, the Director of Plant Operations stated the aforementioned items were replaced down during a recent remodeling project in the building and acknowledged the north stairwell on the first floor was used for storage of the aforementioned items which could interfere with egress.</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. 19.2.1</p>		<p>stairwell.</p> <p>4.Results of the monthly inspection will bereported to the QA Committee monthly, on going.</p>	
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	<p>Based on observation and interview, the facility failed to ensure not more than one delayed egress lock device was provided in any egress path as permitted by NFPA 101 19.2.2.2.4 Exception No. 2 in 8 of 12 egress paths. A.19.2.2.2.4 states, the intent of the provision is that a person following the natural path of the means of egress not encounter more than one delayed release device along that path of travel to an exit. Thus, each door from the multiple floors of a building that opens into an enclosed stair is permitted to have its own delayed release device, but an additional delayed release device is not permitted at the level of exit discharge on the door that discharges people from the enclosed stair to the outside. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Director of Plant Operations and the Van Driver during a tour of the facility from 11:30 a.m. to 1:50 p.m. on 11/09/15, the path of egress for second and third floor residents using any of the four exit stairwells for the facility was provided with two delayed egress locks. A delayed egress lock was located on the first floor at each of the four exit stairwells which was the cause of the second delayed egress lock</p>	K 0038	<p>K038</p> <ol style="list-style-type: none"> 1. The exterior stairwell doors have had the maglocks removed. 2. No residents were affected. 3. An alarm will be placed on the door that will sound if the door is opened. 4. Doors alarms will be added to the preventative maintenance log and checked for proper function. 	11/27/2015			

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K 0144 SS=F Bldg. 01	<p>in the path of egress from the upper floors. Each of the four exit stairwell exit doors on the first, second and third floor was provided with the necessary signage indicating it was a delayed egress lock and each exit door released when pushed for 15 seconds. Based on interview at the time of the observations, the Director of Plant Operations acknowledged the path of egress for second and third floor residents using any of the four exit stairwells for the facility was provided with two delayed egress locks.</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>Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 4 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power</p>	K 0144	<p>K144</p> <p>1. Generator load test was completed in October and monthly there after. 2. No residents were affected. 3. Generator load test is currently on the preventative maintenance log. 4. Results of the monthly</p>	11/27/2015

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	<p>Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Weekly/Monthly Load Test" and "Direct Supply Tels</p>		generator load test will be reported as completed monthly to the QA committee on an on going basis.		

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	<p>Logbook Documentation: Emergency Generator" documentation with the Director of Plant Operations during record review from 9:15 a.m. to 11:30 a.m. on 11/09/15, documentation of monthly load testing for June 2015 through September 2015 was not available for review. Based on interview at the time of record review, the Director of Plant Operations stated monthly load testing was documented on "Weekly/Monthly Load Test" through May 2015, staff turnover after May 2015 prohibited the facility from documenting monthly load testing through September 2015 and acknowledged monthly load testing documentation for June 2015 through September 2015 was not available for review.</p> <p>3.1-19(b)</p>			