

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2013
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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
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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: 07/26/13</p> <p>Facility Number: 004700 Provider Number: 155741 AIM Number: 100266630</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Friendship Healthcare 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.</p> <p>This one story facility with a partial basement 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 corridor. The facility has smoke detectors hard wired to the fire</p>	K010000	<p>This plan of correction is the center's credible allegation of compliance. Preparation and/or completion of this plan of correction does not constitute admission or agreement by the provider of the facts alleged of the conclusion set forth the in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by state and federal law.</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>alarm system installed in all resident sleeping rooms. The facility has a capacity of 53 and had a census of 39 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached storage shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/30/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>1. Based on observation and interview, the facility failed to ensure doors protecting corridor openings were smoke resistive for 1 of 40 corridor doors. This deficient practice could affect 15 residents, staff or visitor in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:35 a.m. to 1:15 p.m. on 07/26/13, the Main Dining Room is open to the corridor and the kitchen entry door from the Main Dining Room is a Dutch door which is not equipped with an astragal, rabbet or bevel to resist the passage of smoke. A rubber molding strip was affixed to the top of the bottom leaf of the Dutch door and had a one half inch gap between the bottom leaf and the top leaf near the door handle when the door set was closed and latched into the door frame. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the</p>	K010018	A repair of all deficiencies was made and this was the corrective action accomplished for those residents found to be affected by the deficient practice. A check of all other residents having the potential to be affected by the same deficient practice was made as well. The measures that will be put into place to ensure that the deficient practice does not recur again will be a monthly examination of all doors that would have a potential to put residents at risk or in danger. A signature of the administrator and or assistant administrator to ensure the deficient practice will not recur again will monitor the corrective action. This will be the quality assurance program that we will put into place, and the systemic changes will be completed by August 25, 2013 or sooner.	08/25/2013

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	<p>aforementioned Dutch door is not equipped with an astragal, rabbet or bevel and the aforementioned gap was not resistive to the passage of smoke.</p> <p>3-1.19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure doors protecting corridor openings were smoke resistive for 1 of 28 resident sleeping room corridor doors. This deficient practice could affect 28 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:35 a.m. to 1:15 p.m. on 07/26/13, the gap between the face of the corridor door to resident sleeping Room S14 and the door stop measured 3/4th of an inch when closed and latched. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the gap between the face of the corridor door to resident sleeping room S14 and the door stop was greater than one half inch when closed and latched.</p> <p>3-1.19(b)</p>				

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 Dutch doors protecting hazardous areas were equipped with an astragal. LSC 18.3.6.3.6 states Dutch doors shall be constructed to resist the passage of smoke, both the upper leaf and the lower leaf shall be equipped with a latching device, and the meeting edges of the upper and lower leaves shall be equipped with an astragal, rabbet, or a bevel. This deficient practice could affect 15 residents, staff or visitors in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:35 a.m. to 1:15 p.m. on 07/26/13, the kitchen entry door from the Main Dining Room is a Dutch door and is not equipped with an astragal, rabbet or bevel. A rubber molding strip was affixed to the top of the bottom leaf of the Dutch door and had a one half inch gap between the bottom leaf and the top leaf near the door handle when the each</p>	K010029	A repair of this deficiency was made and this was the corrective action accomplished for those residents found to have been affected by the deficient practice. By making the repair of this deficiency will protect other residents that would be identified of having the potential to be affected by the same deficient practice. A constant inspection of the Dutch door will be put into place to ensure that the deficient practice does not recur. The Dutch door will be added to our daily rounds checklist, and a minimum of three days a week the door will be inspected to insure the door stays in compliance with life safety code standards. This is the corrective action, and quality assurance program that will be put into place to be monitored to ensure the deficient practice will not recur, and the systemic changes will be completed by August 25, 2013 or sooner.	08/25/2013			

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	<p>door leaf was closed and latched into the door frame. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned Dutch door is not equipped with an astragal, rabbet or bevel.</p> <p>3-1.19(b)</p>			

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K010039 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 exit access corridors had a clear and unobstructed exit width of at least 8 feet (96 inches). This deficient practice could affect 15 residents, staff or visitors needing to exit the facility near the Main Dining Room in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 11:35 a.m. to 1:15 p.m. on 07/26/13, an iced tea dispenser on top of a food cart and two blue plastic food transport carts were being stored in the corridor outside the Main Dining Room at 12:40 p.m. In addition, at 9:10 a.m. during entry observations of the facility, the aforementioned food carts were being stored in the corridor outside the Main Dining Room. The corridor outside the Main Dining Room is marked as an exit and the unobstructed width of the aforementioned corridor measured eight feet wide. The two blue plastic food</p>	K010039	<p>The relocation of the hydration station and the two blue hot carts will be the corrective action accomplished for those residents found to have been affected by the deficient practice. By relocating said obstructions, those other residents identified in having the potential to be affected by the same deficient practice will be the corrective action taken. The hydration station will be relocated to the dinning room, and the two blue hot carts will be relocated to the kitchen. This will be the systemic change that will be put into place to ensure that the deficient practice does not recur. The quality assurance program will be an in-service held explaining the 8- foot rule in aisles and corridors to all staff. All aisles and corridors will be monitored on a daily bases by all staff to ensure the deficient practice will not recur, and the systemic changes will be completed by August 25, 2013 or sooner.</p>	08/25/2013			

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	<p>transport carts protruded two feet into the corridor and the storage of the iced tea dispenser also served to decrease the exit corridor width from eight feet. Based on interview at the time of observations, the Maintenance Supervisor acknowledged storage of the aforementioned food carts decreased the unobstructed width of the corridor outside the Main Dining Room to less than eight feet.</p> <p>3.1-19(b)</p>			

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K010050 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly 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. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second shift for 3 of 4 quarters. This deficient practice affects all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Maintenance Supervisor during record review from 9:15 a.m. to 11:35 a.m. on 07/26/13, third shift fire drills conducted on 10/31/12, 11/27/12, 02/04/13, and 05/24/13 were conducted, respectively, at 3:30 p.m., 3:15 p.m., 3:30 p.m. and 3:15 p.m. Based on interview at the time of record review, the Maintenance Supervisor acknowledged second shift fire drills were not conducted at unexpected times under varying conditions.</p>	K010050	The awareness and acknowledgement of this deficient practice is the corrective action accomplished for those residents found to have been affected, and by understanding the importance of holding fire drills at unexpected times is the corrective action taken. This will help us identified other residents having the potential to be affected by the same deficient practice. The systemic changes that will be made to ensure that the deficient practice does not recur will be adding a time to our ready-made schedule for fire drills. A signature of the administrator and or assistant administrator to ensure the deficient practice will not recur again will monitor the corrective action. This will be the quality assurance program that we will put into place, and the systemic changes will be completed by August 25, 2013 or sooner.	08/25/2013			

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K010052 SS=C	<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 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:35 a.m. to 1:15 p.m. on 07/26/13, access to the fire alarm system breaker located in the electrical panel by Room S15 was not locked. Breaker # 34 in the aforementioned</p>	K010052	The installation of an individual single pull circuit breaker lock was the corrective action accomplished for those residents found to be affected by the deficient practice, and installing the said device is how other residents having the potential to be affected by the same deficient practice will be identified. A constant check of the device installed will be the measures put into place to ensure that the deficient practice does not recur. The device installed will be added to our daily rounds checklist, and a minimum of three days a week the device will be inspected to insure it stays in compliance with life safety code standards. This is the quality assurance program that will be put into place, and how the corrective action will be monitored to ensure the deficient practice will not recur. The systemic changes will be completed by August 25, 2013 or sooner.	08/25/2013			

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	<p>electrical panel was identified as "Fire Alarm CKT". Based on interview at the time of observation, the Maintenance Supervisor acknowledged access to the aforementioned fire alarm system breaker located in the electrical panel by Room S15 was not locked.</p> <p>3.1-19(b)</p>			

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K010067 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A</p> <p>Based on record review, observation and interview; the facility failed to ensure 84 of 136 fire dampers in the ductwork at smoke barriers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Superior Systems & Supply "Fire/Smoke Damper Maintenance Record" documentation dated 05/16/13 with the Maintenance</p>	K010067	<p>The corrective action that was accomplished for those residents found to have been affected by the deficient practice will be an investigation into the operation of said fire dampers. This same corrective action was accomplished for other residents identified as having the potential to be affected by the same deficient practice. Upon the investigation of fire dampers Superior Systems & Supply has found a way to inspect said dampers to be in compliance with Life Safety. The systemic changes that will be made to ensure that the deficient practice does not recur will be an inspection of each fire damper by Superior Systems & Supply. SSS (Superior Systems & Supply) will record all their findings and repair any and all deficiencies found. Friendship Healthcare Maintenance Supervisor will monitor this corrective action by storing the report findings of SSS in a binder. He will also record the date in his computer so as to remind him in four years to inspect all fire dampers. The date the systemic changes will be completed by August 25, 2013 or soon after. A Waiver Request will</p>	08/25/2013
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	<p>Supervisor during record review from 9:15 a.m. to 11:35 a.m. on 07/26/13, 136 fire dampers in the facility were inspected and cleaned, however, the aforementioned inspection record stated "NA" as the result for "Tested", "Fully Closed", "Latch Checked", "Fusible Link Removed" and "Moving Parts Lubricated" for each fire damper. "Fire/Smoke Damper Maintenance Record" documentation dated 05/25/10 and 07/26/12 performed by the facility indicated 52 facility fire dampers had been operated to verify they fully close within the most recent four year period. Based on observations with the Maintenance Supervisor during a tour of the facility from 11:35 a.m. to 1:15 p.m. on 07/26/13, two fire dampers were observed located in the HVAC supply and return vents in the MDS Office. Based on interview at the time of record review and of the observations, the Maintenance Supervisor stated no fire dampers have been added to the facility in the last four years and acknowledged documentation of the necessary maintenance and inspection for 84 of 136 fire dampers in the facility was not available for review.</p> <p>3.1-19(b)</p>		<p>be completed and faxed to ISDH today to request a 90 day extension in case SSS is unable to complete the inspection and service on all of the dampers prior to 8/25/2013.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2013
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