

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  02/21/2012
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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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K0000	<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: 02/21/12</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 areas open to the corridor. The facility has a capacity of 53 and had a census of 48 at</p>	K0000		

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>the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/24/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
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K0025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-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 in approved 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. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 smoke barriers was maintained to provide the one hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect any resident, staff or visitor in the vicinity of the smoke barrier wall by the kitchen entrance.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of</p>	K0025	<p>1) The smoke barrier wall above the ceiling by the kitchen entrance will be repaired and firestopped to eliminate the 5" hole and the 1" diameter space around the wire cited in the 2567. This will be completed by March 22, 2012.</p> <p>2) All residents in the facility are identified as having potential to be affected.</p> <p>3) A quarterly inspection of smoke barriers will be added to the maintenance checklist as a method to identify any areas in need of repair.</p> <p>4) The maintenance checklist will be reviewed by the Quality Assurance Committee quarterly as a method to monitor continuing compliance. The Maintenance Supervisor and Administrator are responsible for compliance.</p> <p>5) Completion date: March 22, 2012</p>	03/22/2012	

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	<p>the facility from 10:55 a.m. to 1:00 p.m. on 02/21/12, the smoke barrier wall above the ceiling by the kitchen entrance had a five inch by five inch hole cut in the drywall which was not firestopped, and a one inch in diameter space surrounding one wire which was penetrating the smoke barrier which was not firestopped. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the five inch by five inch opening in the drywall and a one inch in diameter opening in the smoke barrier wall above the ceiling by the kitchen which were not firestopped.</p> <p>3.1-19(b)</p>				

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K0029 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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 8 doors serving hazardous areas such as the kitchen were self closing and would latch into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the entry door to the kitchen from the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during the tour of the facility from 10:55 a.m. to 1:00 p.m. on 02/21/12, the west entry door to the kitchen from the Main Dining Room is a Dutch door with only the bottom portion equipped with a positive latching device. The top portion of the Dutch door is not equipped with a positive latching device and neither the top portion or the bottom portion of the door is self closing or equipped with an astragal. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the entry door to the kitchen from the</p>	K0029	<p>1) The door from the dining room to the kitchen will be equipped with automatic closing devices and latches so that both the top and bottom halves of the door will close and latch automatically. This will be completed by March 22, 2012.</p> <p>2) All residents in the facility are identified as having potential to be affected.</p> <p>3) A quarterly inspection of doors to hazardous areas such as the kitchen will be included on the maintenance checklist as a method to identify any problems with automatic door closing or latching.</p> <p>4) The maintenance checklist will be reviewed by the Quality Assurance Committee quarterly as a method to monitor continuing compliance. The Maintenance Supervisor and Administrator are responsible for compliance.</p> <p>5) Completion date: March 22, 2012</p>	03/22/2012			

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	Main Dining Room is not self closing and failed to latch into the door frame.  3.1-19(b)			

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K0038 SS=E	<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. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 4 of 5 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 18.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice affects at least 80 % of residents and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 10:55 a.m. to 1:00 p.m. on 02/21/12, all five exit doors were magnetically locked and could be opened by entering a four digit code, but the code was not posted at any exit except the</p>	K0038	<p>1) Exit codes will be posted beside each exit door by March 22, 2012.</p> <p>2) All residents in the facility are identified as having potential to be affected.</p> <p>3) The codes by the exit doors will be checked three times weekly to make sure that they are present. This will be documented on the Maintenance Checklist.</p> <p>4) The maintenance checklist will be reviewed by the Quality Assurance Committee quarterly as a method to monitor continuing compliance. The Maintenance Supervisor and Administrator are responsible for compliance.</p> <p>5) Completion date: March 22, 2012</p>	03/22/2012			

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	<p>Northwest exit. Based on interview with the Building Owner during the exit interview from 1:00 p.m. to 1:10 p.m. on 02/21/12, the facility does not know the percentage of residents who have a clinical diagnosis requiring specialized security measures and acknowledged the code was not posted at four of five exits.</p> <p>3.1-19(b)</p>			

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K0046 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1</p> <p>1. Based on record review, observations and interview; the facility failed to ensure emergency lighting was provided in accordance with LSC 7.9 for 19 of 19 battery powered emergency lights for the last 12 months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hr duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect any resident, staff or visitor in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor from 9:15 a.m. to 10:55 a.m. on 02/21/12, documentation of an annual test of battery powered emergency lights in the facility was not available for review. Based on observations with the Maintenance</p>	K0046	<p>1) The two battery operated emergency lights at the NW exit have had their batteries replaced and are now functional.</p> <p>2) All residents in the facility have been identified as having potential to be affected.</p> <p>3) A new "Battery Operated Lights Test Log" has been implemented to record both the monthly functional tests and the annual duration tests.</p> <p>4) The "Battery Operated Lights Test Log" will be reviewed by the Quality Assurance Committee quarterly as a method to monitor continuing compliance. The Maintenance Supervisor and Administrator are responsible for compliance.</p> <p>5) Completion date: March 22, 2012</p>	03/22/2012			

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	<p>Supervisor during a tour of the facility from 10:55 a.m. to 1:00 p.m. on 02/21/12, nineteen battery powered emergency lights were observed in the facility. Based on interview at the time of record review, the Maintenance Director acknowledged no documentation of annual testing of each battery powered emergency light was available for review.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 19 battery operated emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.4 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during the tour of the facility from 10:55 a.m. to 1:00 p.m. on 02/21/12, two battery operated emergency lights at the Northwest exit</p>			

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	<p>failed to illuminate when the test button was pressed four times. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the two battery operated emergency lights at the Northwest exit failed to illuminate when the test button was pressed.</p> <p>3.1-19(b)</p>			

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K0048 SS=E	<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. 18.7.1.1</p> <p>Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 18.7.2.2 requires written health care occupancy fire safety plans 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 evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice affects any resident, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire safety plan titled "Fire Procedure" during record review with the Maintenance Supervisor from 9:15 a.m. to 10:55 a.m. on 02/21/12, the fire safety plan did not address the use of ABC type fire extinguishers and the K class fire</p>	K0048	<ol style="list-style-type: none"> <li>1) The fire safety plans will be revised to include use of the kitchen fire extinguishers by March 22, 2012.</li> <li>2) All residents in the facility have been identified as having potential to be affected.</li> <li>3 &amp; 4) The fire safety plans will be reviewed by the Quality Assurance Committee after they have been revised, and will be reviewed annually to assure continuing compliance. The Maintenance Supervisor and Administrator are responsible for compliance.</li> <li>5) Completion date: March 22, 2012</li> </ol>	03/22/2012			

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	<p>extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. 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 either the ABC type fire extinguisher or the K class fire extinguisher.</p> <p>3.1-19(b)</p>			

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K0050 SS=F	<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>1. Based on record review and interview, the facility failed to document fire drills on the first and third shift for 2 of 4 calendar quarters. This deficient practice affects all residents, staff and visitors.</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 10:55 a.m. on 02/21/12, fire drill records were not available for review for the third shift for the first quarter of 2011, or the first shift for the third quarter of 2011. Based on interview at the time of record review, the Maintenance Supervisor acknowledged fire drill records for the aforementioned shifts and quarters were not available for review.</p> <p>3.1-19(b) 3.1-51(c)</p>	K0050	<p>1) The missing third shift fire drill for the first quarter of 2011 was cited on the April 2011 life safety survey. Our plan of correction was implemented to address that in 2011 by adding a third shift fire drill in April to make up for the one that was missed in the first quarter. Beginning now, second shift fire drills will be held at various, unexpected times as required by regulations.</p> <p>2) All residents in the facility have been identified as having potential to be affected.</p> <p>3) The Maintenance Supervisor will inform the Administrator of fire drill times each time a drill is held. The Administrator and Maintenance Supervisor will make sure that each shift has fire drills at various times throughout the year.</p> <p>4) The fire drills will be reviewed by the Quality Assurance Committee quarterly as a method to monitor continuing compliance. The Maintenance Supervisor and</p>	03/22/2012			

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	<p>2. 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 4 of 4 quarters. This deficient practice affects all residents, staff and visitors.</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 10:55 a.m. on 02/21/12, second shift fire drills conducted on 04/29/11, 07/28/11, 10/24/11 and 01/22/12 were conducted between 3:45 p.m. and 4:32 p.m. Based upon 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> <p>3.1-19(b) 3.1-51(c)</p>		<p>Administrator are responsible for compliance. 5) Completion date: March 22, 2012</p>		

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NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
(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			
K0064 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 portable K class fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents, staff or visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of</p>	K0064	<p>A placard will be conspicuously placed by the portable K class fire extinguisher in the kitchen stating that the fire protection system shall be activated prior to using the K class portable fire extinguisher by March 22, 2012.</p> <p>2) All residents in the facility have been identified as having potential to be affected.</p> <p>3) The presence of that placard will be confirmed monthly and will be added to the Maintenance Checklist to document that it is still present and legible.</p> <p>4) The Maintenance Checklist will be reviewed by the Quality Assurance Committee quarterly as a method to monitor continuing compliance. The Maintenance Supervisor and Administrator are responsible for compliance.</p> <p>5) Completion date: March 22, 2012</p>	03/22/2012			

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	<p>the facility from 10:55 a.m. to 1:00 p.m. on 02/21/12, a placard was not conspicuously placed near the K class portable fire extinguishers located in the kitchen which states the fire protection system shall be activated prior to using the K class portable fire extinguisher. Based on interview at the time of observation, the Maintenance Supervisor acknowledged a placard was not conspicuously placed near the K class portable fire extinguishers stating the fire protection system shall be activated prior to using the K class portable fire extinguisher.</p> <p>3.1-19(b)</p>				

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K0066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(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.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 18.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container for 1 of 1 areas where smoking was permitted. This deficient practice could affect any resident, staff or visitor if needing to exit the facility from the Dining Room exit during a fire emergency.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of</p>	K0066	<p>1) The cigarette butts have been removed from the smoking area. A metal receptacle with a self-closing cover into which ashtrays can be emptied has been placed in the designated smoking area.</p> <p>2) All residents in the facility have been identified as having potential to be affected.</p> <p>3) All staff who monitor resident smoking will be inserviced by March 22, 2012 to review smoking policies, including proper disposal of cigarette butts in ash trays and use of the metal receptacle with self closing</p>	03/22/2012			

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	<p>the facility from 9:15 a.m. to 10:55 a.m. on 02/21/12, the outside smoking area near the Dining Room exit had in excess of one hundred butts strewn about the ground. Furthermore, ten cigarette butts were observed in a plastic container which was full of waste paper. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the facility's employees and residents disposed of cigarette butts on the ground and into a plastic container full of waste paper products.</p> <p>3.1-19(b)</p>		<p>covers for cigarette butts and ashes only, and not for trash. 4) The Maintenance Supervisor will observe the smoking area on his daily rounds to be sure that staff is following the policies, and that cigarettes are properly disposed of. The Maintenance Supervisor will report to the Quality Assurance Committee quarterly on his observations of the designated smoking area during daily rounds. The Maintenance Supervisor and Administrator are responsible for compliance. 5) Completion date: March 22, 2012</p>		