

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/01/2014
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NAME OF PROVIDER OR SUPPLIER  NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
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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: 10/01/14</p> <p>Facility Number: 000131 Provider Number: 155226 AIM Number: 100274910</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, North Capitol Nursing and 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 four 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 smoke</p>	K010000	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 of any violation or regulation. This provider respectfully requests that the 2567 PLAN OF CORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION AND REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEY RE-VISIT on or after 10.17.14.	

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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K010025 SS=E	<p>detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 123 and had a census of 114 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 10/02/14.</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 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 3 of 4 ceiling smoke barriers were protected to</p>	K010025	It is the practice of this provider to ensure smoke barriers are constructed to provide at least a one half hour fire resistance	10/10/2014			

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	<p>maintain the smoke resistance 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 42 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 11:10 a.m. to 2:10 p.m. on 10/01/14, the following openings were noted in the ceiling smoke barrier on the second, third and fourth floor which failed to maintain the smoke resistance of the ceiling smoke barrier:</p> <ol style="list-style-type: none"> <li>two separate three inch in diameter holes for the passage of twenty cables through each of the two openings in the ceiling of the second floor Housekeeping Room by the nurses station.</li> <li>one three inch in diameter hole for the passage of twenty cables in the ceiling of the third floor Housekeeping Room by the nurses station.</li> <li>two separate three inch in diameter</li> </ol>		<p>rating in accordance with 8.3. <b>What corrective action will be accomplished for those residents found to have been affected?</b> The openings in the ceilings smoke barrier on the second, third, and fourth floors were caulked with fire rated caulking. <b>How other residents will be identified and what correction action taken?</b> All housekeeping closets were inspected to ensure there were no openings in the fire barrier. <b>What systemic changes will be made to ensure the deficient practice does not recur?</b> The maintenance department will perform monthly inspections of the housekeeping closets to ensure there are no openings in the fire barriers. <b>How the corrective action will be monitored?</b> An Environmental Safety CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by the Maintenance Director or designee. The Environmental Safety audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including</p>				

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K010027 SS=E	<p>holes for the passage of twenty cables through each of the two openings in the ceiling of the fourth floor Housekeeping Room by the nurses station.</p> <p>Based on interview at the time of the observations, the Executive Director and the Maintenance Director acknowledged the aforementioned openings failed to maintain the smoke resistance of the ceiling smoke barrier.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 2 of 11 sets of smoke barrier doors would provide a smoke resistant barrier. LSC 19.3.7.6 requires doors in smoke barriers shall comply with Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the</p>	K010027	<p>separation of the responsible employee. <b>Date of compliance:</b> 10.10.14</p> <p>It is the practice of this provider to ensure doors are self-closing or automatic closing in accordance with 19.2.2.2.6. <b>What corrective action will be accomplished for those residents found to have been affected?</b> The identified doors will be repaired to ensure closing. <b>How other residents will be identified and what</b></p>	10/22/2014

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	<p>minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 50 residents, staff and visitors if smoke was allowed to move from one smoke compartment to another.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 11:10 a.m. to 2:10 p.m. on 10/01/14, the set of smoke barrier doors in the corridor by Room 225 and the set of smoke barrier doors in the corridor by the lobby each swing in the same direction and are equipped with a door frame mounted coordinator but failed to provide a smoke resistant barrier when the smoke barrier door sets were closed. Each frame mounted coordinator failed to function which caused a six inch gap between each set of corridor doors when each set of smoke barrier doors were closed. Based on interview at the time of the observations, the Executive Director and the Maintenance Director acknowledged each set of the aforementioned smoke barrier doors failed to provide a smoke resistant barrier when closed.</p> <p>3.1-19(b)</p>		<p><b>correction action taken?</b> All fire doors were inspected to ensure proper closure. <b>What systemic changes will be made to ensure the deficient practice does not recur?</b> The maintenance department will perform monthly inspections of the fire doors to ensure proper closure. <b>How the corrective action will be monitored?</b> An Environmental Safety CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by the Maintenance Director or designee. The Environmental Safety audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. <b>Date of compliance:</b> 10.22.14</p>				

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K010029 SS=E	<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 1 of 13 doors serving hazardous areas such as soiled linen rooms rooms are provided with positive latching devices to latch the door into the door frame. This deficient practice could affect 22 residents, staff and visitors in the vicinity of the soiled linen room by Room 425.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Director during a tour of the facility from 11:10 a.m. to 2:10 p.m. on 10/01/14, the latching mechanism to the corridor door to the soiled linen room by Room 425 was removed which caused the door to fail to latch into the door frame. Based on interview at the time of observation, the Executive Director and the</p>	K010029	<p>It is the practice of this provider to ensure doors serving hazardous areas are provided with positive latching devices to latch the door into the door frame. <b>What corrective action will be accomplished for those residents found to have been affected?</b> The identified door was repaired to ensure positive latching. <b>How other residents will be identified and what correction action taken?</b> All soiled utility doors were inspected to ensure proper functionality. <b>What systemic changes will be made to ensure the deficient practice does not recur?</b> The maintenance department will perform monthly inspections of the soiled utility doors to ensure proper latching. <b>How the corrective action will be monitored?</b> An Environmental Safety CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for</p>	10/02/2014

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K010046 SS=C	<p>Maintenance Director acknowledged the aforementioned hazardous area door was not provided with a positive latching device to latch the door into the door frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 1 of 7 battery powered lights for the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds 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</p>	K010046	<p>three months by the Maintenance Director or designee. The Environmental Safety audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. <b>Date of compliance:</b> 10.02.14</p> <p>It is the practice of this provider to ensure emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9. <b>What corrective action will be accomplished for those residents found to have been affected?</b> The battery was replaced in the emergency light in the generator room. <b>How other residents will be identified and what correction action taken?</b> All emergency lights were tested and all batteries were replaced. <b>What systemic changes will be made to ensure the deficient practice does not recur?</b> The maintenance department will perform monthly inspections of the emergency lighting. <b>How the corrective action will be monitored?</b> A preventative</p>	10/10/2014			

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	<p>authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Emergency Lights Test Log for 2013 and 2014" documentation for the most recent twelve month period with the Executive Director and the Maintenance Director during record review from 9:15 a.m. to 11:10 a.m. on 10/01/14, the following was noted:</p> <p>a. documentation of monthly functional testing for the battery powered emergency light located at the emergency generator for the most recent twelve month period was not available for review.</p> <p>b. documentation of an annual test for the battery powered emergency light located at the emergency generator for not less than 1 ½ -hr duration for the most recent twelve month period was not available for review.</p> <p>Based on interview at the time of record review, the Maintenance Director stated a total of seven battery powered emergency lights are located in the facility but the battery operated emergency light at the emergency generator is not included in the aforementioned documentation and acknowledged documentation of an</p>		<p>maintenance audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by the Maintenance Director or designee. The audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. <b>Date of compliance: 10.10.14</b></p>	

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K010062 SS=B	<p>annual test for not less than 1 ½ -hr duration and monthly functional testing for the battery powered emergency light located at the emergency generator for the most recent twelve month period was not available for review. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 11:10 a.m. to 2:10 p.m. on 10/01/14, a total of seven battery powered emergency lights were located in the facility and each battery powered emergency light operated when their respective test button was pushed except for the light at the emergency generator location.</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>Based on observation and interview, the facility failed to ensure 1 of over 100 sprinkler heads were 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 24 residents, staff</p>	K010062	<p>It is the practice of this provider to ensure escutcheon plates used with a recessed or flush-type sprinkler are a part of a listed sprinkler assembly.</p> <p><b>What corrective action will be accomplished for those residents found to have been affected?</b> Identified escutcheon plate was replaced. <b>How other residents will be identified and what correction</b></p>	10/10/2014

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K010144 SS=C	<p>and visitors in the vicinity of the second floor Nursing Supplies closet.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Director during a tour of the facility from 11:10 a.m. to 2:10 p.m. on 10/01/14, the automatic sprinkler located on the ceiling of the second floor Nursing Supplies closet had a missing escutcheon plate which left a two inch opening in the ceiling. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned automatic sprinkler had a missing escutcheon plate which left a two inch opening in the ceiling.</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><b>action taken?</b> All sprinkler heads were inspected by the Director of Maintenance to ensure escutcheon plates were in place. <b>What systemic changes will be made to ensure the deficient practice does not recur?</b> The maintenance department will perform monthly inspections of the sprinkler heads. <b>How the corrective action will be monitored?</b> A Environmental Safety CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by the Maintenance Director or designee. The audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. <b>Date of compliance:</b> 10.10.14</p>	

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	<p>Based on observation and interview, the facility failed to provide adequate emergency task lighting in and around the generator set in accordance with NFPA 101, 2000 Edition, Life Safety Code. Section 19.2.9.1 states emergency lighting shall be provided in accordance with Section 7.9. LSC Section 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires the EPS (Emergency Power Supply) equipment location shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Director during a tour of the facility from 11:10 a.m. to 2:10 p.m. on 10/01/14, the battery powered emergency light located in generator room did not function when the test button was depressed five times. Based on interview at the time of observation, the Executive Director acknowledged the battery powered emergency light located in generator</p>	K010144	<p>It is the practice of this provider to ensure adequate lighting in and around the generator. <b>What corrective action will be accomplished for those residents found to have been affected?</b> The battery was replaced in the emergency light in the generator room. <b>How other residents will be identified and what correction action taken?</b> All emergency lights were tested and all batteries were replaced. <b>What systemic changes will be made to ensure the deficient practice does not recur?</b> The maintenance department will perform monthly inspections of the emergency lighting. <b>How the corrective action will be monitored?</b> A preventative maintenance audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by the Maintenance Director or designee. The audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. <b>Date of compliance:</b> 10.10.14</p>	10/10/2014			

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	room did not function when the test button was depressed.  3.1-19(b)				