

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/29/2013
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NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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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: 04/29/13</p> <p>Facility Number: 000105 Provider Number: 155198 AIM Number: NA</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Marquette was found not in compliance with Requirements for Participation in Medicare, 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 two story building with a basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor, areas open to the corridor and hard wired smoke detectors in resident rooms. The facility has a capacity of 102 and had a</p>	K010000		
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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>census of 80 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/09/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010017 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 open use areas was separated from the corridor, or met an Exception. LSC 19.3.6.1, Exception # 1 Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke</p>	K010017	_K-017What corrective actions will be accomplished for those residents found to have been affected by this practice? No residents were affected by the absence of the electrically supervised automatic smoke detector. The automatic smoke damper is in place and was overlooked during the survey (See photos of existing damper (Exhibit A). How have other residents having the potential to be affected by the same practice been identified and what corrective action has been taken? Any resident using the hallway to the main entrance could be affected. The space identified as has been equipped with an electrically supervised automatic smoke detector. (See photo and work order of installation Exhibit B) The space	05/14/2013			

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	<p>detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect 26 residents adjacent to the Front Reception office by the front entrance as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 04/29/13 at 2:50 p.m. with the Maintenance Supervisor, the Reception office next to the front entrance had sliding glass windows separating the office from the corridor and it was open to the corridor at the time of observation. Furthermore, there was an open space between the glass panes as they slide horizontally along its metal track. Exception # 1, requirement (c) of the Life Safety Code, Chapter 19.3.6.1 was not met as follows: the open area was not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. Based on interview on 04/29/13 at 2:41 p.m. with the Maintenance Supervisor, it was acknowledged the Reception office which was open to the corridor without supervision from the</p>		<p>identified was already equipped with two quick response sprinkler heads; thereby, significantly reducing any potential danger to residents, staff or visitors. What measures will be put into place or what systemic changes will be made to ensure that this practice does not recur? The installation of the electrically supervised automatic smoke detector is permanent. The practice will not recur. How will the corrective actions be monitored to ensure this practice does not recur? Quarterly and annual testing and inspection of the fire detection and suppression system pursuant to State and Federal guidelines will be observed. Compliance Date: May 20, 2013</p>				

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	<p>nurse's station and was not protected by automatic smoke detection.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure openings in corridor walls for 1 of 2 elevator rooms was protected with a fire damper or other device which would close automatically upon detection of heat or smoke. This deficient practice could affect any resident on the first floor above the elevator room located in the basement as well as visitors and staff.</p> <p>Finding include:</p> <p>Based on observation on 04/29/13 at 2:40 p.m. with the Maintenance Supervisor, there was a ten inch by twelve inch transom in the corridor wall of the East elevator equipment room. The transom was not equipped with a fire damper or other device which would close automatically on detection of smoke or heat and prevent smoke from entering the corridor from the elevator equipment room. Based on interview on 04/29/13 at 2:41 p.m. with the Maintenance Supervisor, it was acknowledged an unprotected opening or transom in the East elevator equipment room located in the basement would allow smoke from</p>						

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	the elevator equipment room to infiltrate the corridor. 3.1-19(b)				

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K010046 SS=F	<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 observation, record review and interview; the facility failed to ensure 1 of 1 emergency battery backup lights was tested monthly for 30 seconds or annually for 90 minutes duration to ensure lighting during periods of power outages to protect all residents. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. 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 all residents in the facility.</p> <p>Findings include:</p> <p>Based on observation on 04/29/13 at 1:30 p.m. with the Maintenance Supervisor, the battery operated emergency light for the generator was working at the time of</p>	K010046	<p>K-046What corrective actions will be accomplished for those residents found to have been affected by this practice? No residents were found to be affected by this practice.How have other residents having the potential to be affected by the same practice been identified and what corrective action has been taken? All residents could be affected by this practice. What measures will be put into place or what systemic changes will be made to ensure that this practice does not recur? A ninety (90) minute test of the battery operated emergency light to illuminate the dashboard of the emergency generator was conducted on May 16, 2013 with successful results (See Exhibit C, proof of test and PM Works schedule). PM Works, our preventive maintenance software, has been updated to schedule an annual work order to conduct the ninety (90) minute emergency light battery test. (See Exhibit C, proof of test and PM Works schedule) How will the corrective actions be monitored to ensure this practice does not recur? PM Works, our preventative</p>	05/16/2013	

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	<p>inspection.</p> <p>Based on review of Battery Operated Emergency light check list on 04/29/13 at 3:45 p.m. with the Maintenance Supervisor, it was documented the emergency battery backup light was tested for thirty seconds monthly, but there was no record of a ninety minute annual test. Based on interview concurrent with record review, it was acknowledged by the Maintenance Supervisor the emergency battery backup light was tested monthly for thirty seconds, but he was unaware there needed to be an annual ninety minute test.</p> <p>3.1-19(b)</p>		<p>maintenance software, has been updated to schedule an annual work order to conduct the ninety (90) minute emergency light battery test annually. (See Exhibit C) Compliance Date: May 20, 2013</p>		

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K010056 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. These deficient practices could affect any resident as well as staff or visitors.</p> <p>Findings include:</p> <p>Based on observation on 04/29/13 at 2:36 p.m. with the Maintenance Supervisor there was an unsupported steel armover sprinkler pipe which was over thirty</p>	K010056	<p>K-056What corrective actions will be accomplished for those residents found to have been affected by this practice? No residents were found to be affected by this practice.How have other residents having the potential to be affected by the same practice been identified and what corrective action has been taken? All residents could be affected by this practice.What measures will be put into place or what systemic changes will be made to ensure that this practice does not recur? A hanger has been installed on April 30, 2013 to support the steel armover sprinkler pipe located above the main air handler. (See photo, Exhibit D)How will the corrective actions be monitored to ensure this</p>	04/30/2013			

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	<p>inches in length located in the basement above the main air handler. Based on interview on 04/29/13 at 2:37 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned armovert steel sprinkler pipe exceeded twenty four inches in length and was unsupported.</p> <p>3.1-19(b)</p>		<p>practice does not recur? This installation is permanent. There will be no recurrence of this practice. Compliance Date: May 20, 2013</p>				

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K010144 SS=F	<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>1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which 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. This deficient practice could affect all residents</p>	K010144	<p>K-144 What corrective actions will be accomplished for those residents found to have been affected by this practice? No residents have been affected by this practice. How have other residents having the potential to be affected by the same practice been identified and what corrective action has been taken? All residents have the potential to be affected by this practice. What measures will be put into place or what systemic changes will be made to ensure that this practice does not recur? An annual Life Safety Load test was conducted on the emergency generator on May 17, 2013. This test will operate the generator at 95% of capacity for 90 minutes. PM Works, our preventive maintenance software, has been updated to schedule a work order to conduct this test annually. (Exhibit E, copy of load test results, trip-test results, PM Works schedule and modified Generator Test Log) A trip-test of the generator was conducted on May 17, 2013. (See Exhibit E for trip-test documentation) The monthly Generator Test Log has been modified to show results of trip-time performance on the</p>	05/17/2013
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	<p>as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Generator System Testing records and Maintenance logs on 04/29/13 at 4:38 p.m. with the Maintenance Supervisor, the amperage during load was documented to be ten percent or less of the percentage of load capacity for the past twelve months. Based on interview on 04/29/13 at 4:40 p.m. with the Maintenance Supervisor, it was acknowledged the facility had been running the generator at ten percent or less of its load capacity and was unaware the amperage had to be at least thirty percent. No other equivalent method was used to comply with percentage of load capacity for the past twelve months.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to document the generator was capable of automatically restoring electrical power within 10 seconds during load testing for the last 12 of 12 months. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. NFPA 99, 3-5.3.1 requires the</p>		<p>emergency generator. (See Exhibit E, copy of load test results, trip-test results, PM Works schedule and modified Generator Test Log) How will the corrective actions be monitored to ensure this practice does not recur? PM Works, preventive maintenance software, will schedule annual work order for annual load test. Compliance Date: May 20, 2013</p>				

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	<p>emergency system shall be installed and connected to the alternate power source so all functions specified herein for the emergency system will be automatically restored to operation within 10 seconds after the interruption of the normal power source. This deficient practice could affect all residents in the facility as well as visitors and staff if the generator could not supply electricity within 10 seconds of a power failure.</p> <p>Findings include:</p> <p>Based on review of Generator Log records on 04/29/13 at 4:30 p.m. with the Maintenance Supervisor, the number of seconds for the generator to transfer load was not documented. Based on interview on 04/29/13 at 4:33 p.m. with the Maintenance Supervisor, it was acknowledged the information on time of load transfer had not been recorded for the past twelve months and the Maintenance Supervisor was unaware it needed to documented.</p> <p>3.1-19(b)</p>				

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K010160 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observation, interview and record review; the facility failed to ensure the elevator equipment in 2 of 2 elevator equipment rooms was provided with a shunt trip. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect any residents, as well as visitors and staff in the elevator if the sprinkler system was activated in the elevator equipment room.</p> <p>Findings include:</p> <p>Based on observation on 04/29/13 at 2:02 p.m. with the Maintenance Supervisor the two elevator equipment rooms located in the basement on east and west halls were provided with sprinkler head protection. Based on interview on 04/29/13 at 2:03 p.m. with the Maintenance Supervisor, a shunt trip which is designed to</p>	K010160	<p>K- 160What corrective actions will be accomplished for those residents found to have been affected by this practice? No residents were affected by this practice.How have other residents having the potential to be affected by the same practice been identified and what corrective action has been taken? All residents have the potential to be affected by this practice.What measures will be put into place or what systemic changes will be made to ensure that this practice does not recur? Shunt-trips will be installed in the elevator equipment rooms on the east and west end of the hallways in the lower level no later than May 29, 2013. (See Exhibit F copy of work order to be completed by Siemens.)How will the corrective actions be monitored to ensure this practice does not recur? The installation of the shunt-trips is permanent. There will be no recurrence of this practice. Compliance Date: May</p>	05/29/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/29/2013
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(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	
	<p>automatically disconnect power to the affected elevator had not been installed in either of the elevator equipment rooms. Based on the Sprinkler Inspection and Test Report record review on 04/29/13 at 3:45 p.m. with the Maintenance Supervisor, the two elevator equipment rooms located in the basement on the east and west halls were equipped with sprinkler head protection, however, there was no mention of a shunt trip installation in either room. Based on further interview with the Maintenance Supervisor at the time of record review, he stated he was unaware the shunt trip needed to be installed and had never been informed each elevator equipment room needed one.</p> <p>3.1-19(b)</p>		29, 2013		