STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0000	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/09/12 Facility Number: 000376 Provider Number: 155717 AIM Number: 100275510 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, the Alpha Home Association of Greater Indianapolis, Inc. 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. This one story facility 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	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 86 and had a census of 43 at the time of this visit. The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/16/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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NAME OF PROVIDER OR SUPPLIER ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN 46222	

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K0018 SS=E	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 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of 42 resident room corridor doors did not have an impediment to closing and latching. This deficient practice could affect 4 of 43 residents. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:30 p.m. on 07/09/12, the latching mechanism on the corridor door for resident Room 102 and resident Room 105 failed to latch each door into the door frame. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the aforementioned	K0018	**K 018** **Life Safety Code Standard** **Corrective Action Taken Related to this Finding:** **The Alpha Home maintenance director corrected the latching mechanism for the resident room doors in room 102 and in resident room #105.The doors are on a routine schedule for being checked to close in the frame.** **II. Other Residents with Potential to be affected by this finding will be identified by:** **All residents have the potential to be affected by these findings; however, with the monthly routine door checks audit all resident rooms' doors**	08/08/2012

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	resident room doors failed to latch into the door frame. 3.1-19(b)		**have been completed.** - - - **III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows:** **Maintenance monthly door latching checklist.** **This door latching audit reviewed with the administrator and shared with the quality assurance committee for additional recommendations.** - - **IV. Corrective Actions will be monitored to Ensure Compliance by:** - **Monitoring to be done by the administrator. Audit sheet to be reviewed by the quality assurance team for the next quarter, the quality assurance to make recommendation for continuous monitoring after the quarter.**	

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K0025 SS=E	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			
	Based on observation and interview, the facility failed to ensure openings through 1 of 2 smoke barriers were protected to maintain the smoke resistance of each 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 any resident, staff or visitor at the smoke barrier door set near the Hall 2 Nurse's station. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:30 p.m. on	K0025	**K 025 Life Safety Code Standard Corrective Action Taken Related to this Finding: The Maintenance Supervisor replaced the sealing material around the twelve inch duct in the ceiling above the smoke barrier doors in the 100 hallway. With completion of this task the location is fire stopped. II. Other Residents with Potential to be affected by this finding will be identified by: The maintenance director has gone and reviewed all the sprinkler heads and the areas of the building no other areas at present need to be fire stopped. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: Weekly audit checklist of the sprinkler heads to ensure all are closed for the fire stop. IV. Corrective Actions will be monitored to Ensure**	08/08/2012

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	07/09/12, the annular space surrounding a twelve inch duct and a six inch in diameter sprinkler pipe in the attic smoke barrier wall above the ceiling above the smoke barrier door set in the 100 Hall was not firestopped. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the annular space surrounding a twelve inch duct and a six inch in diameter sprinkler pipe in the attic smoke barrier wall in the aforementioned location was not firestopped. 3.1-19(b)		**Compliance by: Weekly audit checklist,, Maintenance supervisor responsible, administrator to monitor forcompliance. Completion date 08/08/12**	

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K0029 SS=E	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 1. Based on observation and interview, the facility failed to ensure 1 of 2 kitchen doors opening into the Main Dining Room would latch into the door frame. This deficient practice could affect any resident, staff and visitors in the vicinity of the Main Dining Room. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:30 p.m. on 07/09/12, the kitchen door which opens into the Main Dining Room and is labeled as the "Out" door is equipped with a latching mechanism but the latching mechanism was stuck in the door and would not latch the Out door into the door frame. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the kitchen Out door	K0029	**K 029 Life Safety Code Standard Corrective Action Taken Related to this Finding: The Maintenance Supervisor replaced the sealing material around the twelve inch duct in the ceiling above the smoke barrier doors in the 100 hallway. With completion of this task the location is fire stopped.** Kitchen door now latching in the frame repaired by maintenance supervisor. Room # 309 repaired latching in the frame **II. Other Residents with Potential to be affected by this finding will be identified by: The maintenance director has gone and reviewed all the sprinkler heads and the areas of the building no other areas at present need to be fire stopped. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as**	08/08/2012

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	opening into the Main Dining Room would not latch into the door frame. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 10 doors serving hazardous areas such as storage rooms greater than fifty square feet in size used to store combustible materials are provided with self closing devices to close and latch the door into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of Room 309. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:30 p.m. on 07/09/12, the access door to Room 309 is not equipped with a self closing device to close and latch the door into the door frame. Room 309 measures 281 square feet and is used to store wood furniture and mattresses. Based on interview at the time of observation, the Maintenance Supervisor stated the former resident room is being utilized as a temporary storage room and acknowledged Room 309 measures greater than fifty square feet, is used to store combustible supplies and the access door is not equipped with a		**Follows: Weekly audit checklist of the sprinkler heads to ensure all are fire stop. Checklist completion for doors latching in the frame. Checklist completion for barrel storage inside a fire rated area. IV. Corrective Actions will be monitored to Ensure Compliance by: Weekly audit checklist, Maintenance supervisor responsible, administrator to monitor for compliance. Completion date 08/08/12**	

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	self closing device. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 2 of 2 soiled linen receptacles near room 203 were stored in an enclosure having a one fire resistance rating, This deficient practice could affect any resident, staff or visitor in the vicinity of Room 203. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:30 p.m. on 07/09/12, one 32 gallon capacity mobile soiled linen receptacle and one 20 gallon capacity mobile soiled linen receptacle each contained soiled linen and were unattended and stored next to each other in the 200 Hall by Room 203. Based on interview at the time of observation, the Maintenance Supervisor acknowledged mobile soiled linen receptacles with more than 32 gallons capacity were not stored in an area providing a one hour fire fire resistance rating. 3.1-19(b)			

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K0046 SS=C	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. 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 1 battery powered emergency lights for 12 of 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 hour duration. Equipment shall be fully operational for the duration of the test. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. 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. Findings include: Based on record review with the Maintenance Supervisor from 9:45 a.m. to 12:30 p.m. on 07/09/12, documentation	K0046	**K 046 – Life Safety Code Standard** **Corrective Action Taken Related to this Finding:** - **The maintenance director has begun the emergency lighting testing running the functional test on battery for 1.5 hours every thirty days within the month.** **The battery powered test is utilized with the generator.** - **II. Other Residents with Potential to be affected by this finding will be identified by:** - **All the residents have the potential to be affected by this finding however; no other residents are affected since the test has begun.** - - -	08/08/2012

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	of 30 day interval testing and an annual test of the battery powered emergency light at the generator located outside the building was not available for review. Based on interview at the time of record review, the Maintenance Supervisor and acknowledged documentation of 30 day interval and annual testing of the battery powered emergency light was not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:30 p.m. on 07/09/12, a battery powered emergency lighting system was observed at the generator location. 3.1-19(b)		**III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows:** - - **The Log sheet has been downloaded from the website, the battery test for generator being conducted with thirty day intervals.** **The monthly test schedule is reviewed by the administrator before the actual test and posttest completion.** - - **IV. Corrective Actions will be monitored to Ensure Compliance by:** - **Maintenance Supervisor responsible, administrator to monitor. Audit review presented to quality assurance committee**	

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K0048 SS=E	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. 19.7.1.1 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 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects any resident, staff and visitor in the vicinity of the kitchen. Findings include: Based on review of "Disaster Preparedness Safety Regulations: Fire Safety" documentation during record review with the Maintenance Supervisor from 9:45 a.m. to 12:30 p.m. on 07/09/12, the facility's written fire safety plan did not address the use of ABC type fire	K0048	**K 048 – Life Safety Code** - **Corrective Action Taken Related to this Finding:** - **The written fire safety policy is posted in the kitchen which states the use of ABC type fire extinguisher for the various types of fires. Additionally, in the kitchen area with a fire in this area the hood suppression system is activated prior to the use of an ABC type fire extinguisher or K class fire extinguisher.** - - **II. Other Residents with Potential to be affected by this finding will be identified by:** - **Potentially all the residents can be affected by this finding, however at the time of this finding no additional residents were identified.** - -	08/08/2012

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	extinguishers and the K-class fire 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 the policy 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. 3.1-19(b)		**III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows:** - **In-service with staff on the various types of fire extinguishers, with the types of fire especially extinguisher to use with a grease fire.** - **IV. Corrective Actions will be monitored to Ensure Compliance by:** - - - **8/08/12**	

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K0050 SS=C	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. 19.7.1.2 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 3 of 4 quarters. This deficient practice affects all occupants in the facility. Findings include: Based on a review of "Fire Drill Report" documentation with the Maintenance Supervisor during record review from 9:45 a.m. to 12:30 p.m. on 07/09/12, third shift fire drills conducted on 07/14/11, 01/24/12 and 04/24/12 were conducted, respectively, at 5:00 a.m., 5:30 a.m. and 5:00 a.m. Based on interview at the time of record review, the Maintenance Supervisor acknowledged third shift fire drills were not conducted at unexpected times under varying conditions. 3.1-19(b)	K0050	**K 50 – Life Safety Code Stand and** **Corrective Action Taken Related to this Finding:** **The Alpha home has access to the ISDPH/GOV website. The fire drill forms on the website have been added to the news forms for the alpha home. Unexpected drills and various time slots are now occurring as evident the mock drill given at the facility. There will be variation in drill times for the fire drills performed at the Alpha home.** - - **II. Other Residents with Potential to be affected by this finding will be identified by:** - **With the adaption and implementation of the new fire drills there will be variation in**	08/08/2012

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			time and elimination of any standard routine. No other residents have been affected by these findings. **III. Measures and Systemic** - **Measures and systemic changes put into place to assure the deficit practice do not recur are s follows, new maintenance director to be responsible for conducting and scheduling of the fire drill. The random drills shall be reviewed the next day after the drill with the interdisciplinary at the morning managers meeting. Also random drills to present to the administrator for review with the quality assurance committee.** **IV. Corrective Actions will be monitored to Ensure Compliance by:** - **Monitoring of the Fire drills by the Maintenance Director, the Administrator responsible for the random time compliance and presentation to the quality assurance committee for compliance.** - - **Completion Date 08 08 12**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
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K0052 SS=F	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 record review and interview, the facility failed to ensure the documentation of the facility fire alarm system annual testing was complete. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system initiating and supervisory device inspections to list the device location. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on a review of SafeCare "Inspection and Testing Form" documentation dated 06/14/12 with the Maintenance Supervisor during record review from 9:45 a.m. to 12:30 p.m. on 07/09/12, the fire alarm system inspection report listed the total number of fire alarm system devices tested but did not list each device location and the result of individual testing. Based on interview at the time of record review, the Maintenance Supervisor stated no additional fire alarm system inspection reports for the last year was available for	K0052	**K 052** **Life Safety Code Standard** **Corrective Action Taken Related to this Finding:** - **The Alpha Home has communicated with the provider of service Safe Care and the provider will make available on the fire alarm inspection report a listing of the devices, the location and the results of the individual device testing.** - **II. Other Residents with Potential to be affected by this finding will be identified by:** - **All residents have the potential to be affected by these finding, these resident were identified with inspection needing additional information to maintain compliance for the building.** - -	08/08/2012

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NAME OF PROVIDER OR SUPPLIER ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN 46222	

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	review and acknowledged the 06/14/12 fire alarm system inspection report did not list each device location and the result of individual testing. 3-1.19(b)		**II. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows:** **A change in the invoice and reporting form where the device is listed, the location and the results of the individual testing.** - - - **V. Corrective Actions will be monitored to Ensure Compliance by:** - **Maintenance Director will be responsible for ensuring the information included on the inspection report.** **Administrator to monitor for compliance.** - - **Completion date 8/8/12**	

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K0062 SS=E	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 Based on observation and interview, the facility failed to ensure 4 of over 100 sprinkler heads in the facility 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 any resident, staff or visitor. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:30 p.m. on 07/09/12, the following areas each had missing escutcheon plates which left a two inch opening in the ceiling into the attic from each area: a. Room 109. b. Linen closet in 100 Hall. c. Clean Utility room by the Laundry. d. Janitor's closet in the Kitchen. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the sprinkler heads in the aforementioned locations each had	K0062	**K 062** **Life Safety Code Standard** **Corrective Action Taken Related to this Finding:** - **Room 109, the linen closet, the clean utility room and the janitor's closet all have the escutcheon plates installed.** **II. Other Residents with Potential to be affected by this finding will be identified by: The maintenance has completed an inspection of the other areas in the building and no other residents are affected by these findings.** **III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows:** - **Weekly walk thru and inspection of the sprinkler area for observation of any missing plates.** **Missing plates replaced.** - - -	08/08/2012

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	missing escutcheon plates which left a two inch opening in the ceiling into the attic from each area. 3.1-19(b)		**IV. Corrective Actions will be monitored to Ensure Compliance by:** **Work orders completed on missing plates, Maintenance director responsible and the administrator to monitor for compliance at the monthly meeting.** **Correction date 8/08/12**	

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NAME OF PROVIDER OR SUPPLIER: ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC		STREET ADDRESS, CITY, STATE, ZIP CODE: 2640 COLD SPRING RD INDIANAPOLIS, IN 46222	

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K0064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 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 staff or visitors in the vicinity of the kitchen. Findings include: Based on observation with the Maintenance Supervisor during a tour of	K0064	**K 064 Life Safety Code Standard Corrective Action Taken Related to this Finding: The written fire safety policy is posted in the kitchen which states the use of ABC type fire extinguisher for the various types of fires. Additionally, in the kitchen area with a fire in this area the hood suppression system is activated prior to the use of an ABC type fire extinguisher or K class fire extinguisher. II. Other Residents with Potential to be affected by this finding will be identified by: Potentially all the residents can be affected by this finding, however at the time of this finding no additional residents were identified. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: In-service with staff on the various types of fire extinguishers, with the types of fire especially extinguisher to use with a grease fire. IV. Corrective Actions will be monitored to Ensure Compliance by: 8/08/12**	08/08/2012

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	the facility from 1:10 p.m. to 3:30 p.m. on 07/09/12, a placard was not conspicuously placed near the K-class portable fire extinguisher 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 extinguisher stating the fire protection system shall be activated prior to using the K-class portable fire extinguisher. 3.1-19(b)			

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K0067 SS=C	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. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on record review, observation, and interview; the facility failed to ensure fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork 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. Findings include: Based on record review with the Maintenance Supervisor from 9:45 a.m. to 12:30 p.m. on 07/09/12, documentation of fire damper testing performed within the last four years was not available for	K0067	**K 067** **Life Safety Code Standard** - **Corrective Action Taken Related to this Finding:** - **The facility has entered into an agreement with a commercial contractor to service the fire dampers, inclusive with this service and cleaning is the fusible link being removed for verification that they fully close. The latch also will receive maintenance with lubrication as necessary.** - **II. Other Residents with Potential to be affected by this finding will be identified by:** - **Other have the potential to be affected however no other resident were affected with the implementation of the agreement to service the dampers.** **III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not**	08/08/2012

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	review. Based on observation with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:30 p.m. on 07/09/12, a fire damper was observed in ductwork above the ceiling by the laundry room entry door in the 200 Hall. Based on interview with the Administrator during the exit conference from 3:40 p.m. to 3:50 p.m. on 07/09/12, the Administrator stated there is more than one fire damper in the facility, a contractor performs annual maintenance on each fire damper but acknowledged documentation of fire damper testing performed within the last four years was not available for review at the time of the survey. 3.1-19(b)		**recur are as Follows:** **The commercial contractor to place the Alpha Home on a regular routine schedule for the four maintenance can be completed.** **IV. Corrective Actions will be monitored to Ensure Compliance by:** - **The facility calendar and schedule maintenance performaced by the contractor is how the practice will be monitored and ensure compliance.** - **Completion 8/8/12**	

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K0069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was cleaned semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1 requires systems serving moderate volume cooking operations shall be inspected semiannually. This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen. Findings include: Based on record review with the Maintenance Supervisor from 9:45 a.m. to 12:30 p.m. on 07/09/12, documentation of semiannual kitchen range hood	K0069	**K 069 Life Safety Code Standard Corrective Action Taken Related to this Finding: The Alpha Home has communicated with Allied and Koorsen, when completing work assignments for the kitchen range hood. All information must be completed for the semiannual cleaning dated, description of the cleaning and the initials of the technician completing the work assignment. II. Other Residents with Potential to be affected by this finding will be identified by: Other residents of the Alpha Home have been identified by the inspection completed with the maintenance supervisor and the contractor. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: Regular computerized semiannual cleaning of the hood is scheduled with the contractor. IV. Corrective Actions will be monitored to Ensure Compliance by: Facility annual calendar to document the twice annual cleaning with the hood. Maintenance director to be responsible and administrator to monitor for**	08/08/2012

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	cleaning was not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:30 p.m. on 07/09/12, Koorsen Fire & Security had affixed two stickers to the kitchen range hood but no date of semiannual cleaning was written on either sticker. Based on interview at the time of record review and observation, the Maintenance Supervisor acknowledged documentation of semiannual kitchen exhaust system cleaning was not available for review. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure hydrostatic testing for 1 of 1 hood extinguishing systems in the kitchen was performed. LSC 9.2.3 requires commercial cooking equipment to be in compliance with NFPA 96, 1998 Edition, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 7-2.2.1 requires automatic fire extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable. a. NFPA 12, Standard on Carbon Dioxide Extinguishing Systems b. NFPA 13, Standard for the Installation of Sprinkler Systems		**compliance. Completion Date 8/08/12**	

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	c. NFPA 17, Standard for Dry Chemical Extinguishing Systems NFPA 17, Standard for Dry Chemical Extinguishing Systems 9-5 requires hydrostatic testing shall be performed by persons trained in pressure testing procedures and safeguards and having available suitable testing equipment, facilities, and an appropriate service manual(s). The following parts of dry chemical extinguishing systems shall be subjected to a hydrostatic pressure test at intervals not exceeding 12 years: (a) Dry chemical containers (b) Auxiliary pressure containers (c) Hose assemblies This deficient practice in the staff only Lower Level would not directly affect residents. Findings include: Based on a review of Allied Safety Services "Fire Equipment Systems Report" documentation dated 05/01/12 with the Maintenance Supervisor during record review from 9:45 a.m. to 12:30 p.m. on 07/09/12, the kitchen range hood suppression system is past due for hydrostatic testing every twelve years. The 05/04/12 report stated "System due for required twelve year maintenance for a 1999 tank. They want a quote for tank & chem." Based on interview at the time			

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	of record review, the Maintenance Supervisor acknowledged the hydrostatic testing had not been done and was past due for twelve year maintenance. 3.1-19(b)			

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K0075 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for mobile soiled linen or trash collection receptacles was not exceeded within any 64 square feet area for 1 of 4 corridors. This deficient practice could affect any resident, staff or visitor in the vicinity of Room 203. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 1:10 p.m. to 3:30 p.m. on 07/09/12, one 32 gallon capacity mobile soiled linen receptacle and one 20 gallon capacity mobile soiled linen receptacle each contained soiled linen and were unattended and stored next to each other in the 200 Hall by Room 203. Based on interview at the time of observation, the Maintenance Supervisor acknowledged mobile soiled linen receptacles with a	K0075	**K 075 Life Safety Code Standard Corrective Action Taken Related to this Finding: Soiled Linen storage container have been assessed for the Alpha Home, The facility will keep the soiled lined inside an enclosed area. II. Other Residents with Potential to be affected by this finding will be identified by: All other residents who reside in the Alpha Home have the potential to be affected , however with the change in location no other residents have been affected. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: Staff daily ensuring the containers are kept in an enclosed area, IV. Corrective Actions will be monitored to Ensure Compliance by: Facility housekeeping/laundry staff responsible for the containers being placed in the enclosed.**	08/08/2012

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	capacity of more than 32 gallons were stored within the 64 square feet corridor area near room 203. 3.1-19(b)		**The maintenance director to monitor. Correction date 8/08/12**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 07/09/2012
NAME OF PROVIDER OR SUPPLIER ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN 46222	

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K0144 SS=F	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. 1. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for 1 of 1 emergency generators was maintained for 24 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on a review of "Generator Exercise	K0144	**K 144** **Life Safety Code Standard** - **Corrective Action Taken Related to this Finding:** - **The Alpha Home had the contractor of service come out and in service and train the maintenance director on the generator. The facility has accessed the website and gathered the weekly generator inspection sheet along with the monthly generator test log. The contractor to assist with direction in running the generator under test load for 30 minutes.** - - **II. Other Residents with Potential to be affected by this finding will be identified by:** - **All residents who reside in the Alpha Home have the potential to be affected by this finding however, no other residents were identified.** - - **Measures and Systemic**	08/08/2012

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	Log Weekly Operational Test" documentation with the Maintenance Supervisor during record review from 9:45 a.m. to 12:30 p.m. on 07/09/12, weekly emergency generator starting battery inspection records for the 24 week period of 07/11/11 through 12/31/11 were not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged weekly emergency generator battery inspection records for 2011 were not available for review. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted for 5 of 12 months 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 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,		**Changes put into Place to Assure Deficit Practices do not recur are as Follows:** **Corrected new form for the weekly test of the generator. New form for documentation for logging the generator test under load. Posting the results in a three binder for record keeping.** **IV. Corrective Actions will be monitored to Ensure Compliance by:The facility will use a weekly audit of the generator test also the monthly generator test is conducted under load. The log shall be reviewed weekly at the managers meeting the maintenance supervisor to be responsible and the administrator to ensure compliance.** **Correction 8/08/12**	

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	using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. 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. Findings include: Based on a review of "Generator Exercise Log Weekly Operational Test" documentation with the Maintenance Supervisor during record review from 9:45 a.m. to 12:30 p.m. on 07/09/12, monthly load test documentation for August 2011 through December 2011 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged monthly load test documentation for the period of August 2011 through December 2011 was not available for review.			

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	3.1-19(b) 3. Based on record review and interview, the facility failed to ensure emergency power would be transferred to 2 of 2 emergency generators within 10 seconds of building power loss for 12 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. 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. Findings include: Based on a review of "Generator Exercise Log Weekly Operational Test" documentation with the Maintenance Supervisor during record review from 9:45 a.m. to 12:30 p.m. on 07/09/12, monthly load test documentation of emergency power transfer time for the period of August 2011 through December 2011 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor			

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	acknowledged monthly load test documentation for emergency power transfer time for the period of August 2011 through December 2011 was not available for review. 3.1-19(b)			