

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155521	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/02/2013
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NAME OF PROVIDER OR SUPPLIER ALEXANDRIA CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1912 S PARK AVE ALEXANDRIA, IN 46001
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/02/13</p> <p>Facility Number: 000518 Provider Number: 155521 AIM Number: 100266670</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident rooms. The facility has a capacity of 70 and had a census of 63 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except one detached garage and one shed for facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/08/13.</p>	K0000	Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of the requirements under the State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	

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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	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0029 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 2 of 3 doors leading to hazardous areas such as rooms which store soiled linen were provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 14 residents on 100 hall and 10 residents on 200 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/02/13 during the tour between 11:55 a.m. to 1:15 p.m. with the Maintenance Supervisor, the shower room on 100 hall and the shower room on 200 hall were used to store soiled linen and each room was greater than fifty square feet in size. The doors were equipped with automatic closing devices, however, when the doors were in</p>	K0029	K029 Plan of Correction affects 14 residents on 100 hall and 10 residents on 200 hall as well as staff and visitors. 1. Maintenance Supervisor replaced automatic closing devices on both 100 and 200 shower rooms as it was determined that the strength was no longer sufficient to consistently latch doors due to the need for requent adjustments. 2. Administrator re-educated the maintenance staff on the importance of assuring shower room doors consistently close and latch. 3. Maintenance Supervisor will monitor all shower room doors to assure that they both close and latch during his daily rounds. 4. The Administrator will monitor the work progress and completion during weekly environmental rounds and review through our Quality Assurance Program. See "ATTACHMENT A"	01/20/2013			

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	<p>the process of closing they would not latch into the door frame. Based on interview on 01/02/13 concurrent with each observation with the Maintenance Supervisor, it was acknowledged the doors leading into the 100 hall and 200 hall shower rooms were equipped with self closing devices on the doors, but the doors would not latch into the door frames.</p> <p>3.1-19(b)</p>			

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K0038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure exit access was arranged so 1 of 7 exits was readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1.10.1 requires means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. LSC Section 7.1.6.4 requires walking surfaces shall be slip resistant under foreseeable conditions. This deficient practice could affect 12 residents on 300 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/02/13 at 2:22 p.m. with the Maintenance Supervisor, the cement walkway used to discharge 300 hall had several inches of snow which had not been removed. Furthermore, the 300 hall exit discharged to a gate which was locked with a lock which required the use of a key. The lock was frozen and the Maintenance Supervisor could not disengage the lock. Based on interview on 01/02/13 at 2:25 p.m. with the Maintenance Supervisor, it was acknowledged the concrete walk had not</p>	K0038	<p>K038 Plan of correction affects 12 residents on 300 hall as well as visitors and staff. 1. Maintenance Supervisor removed frozen lock and drifted snow from the cement walkway used to discharge 300 hall. As area is located next to a golf course and car lot, a snow blind was installed for the winter months as a preventative measure. 2. Administrator re-educated new Maintenance personnel on the importance of maintaining egress free from all obstructions or impediments. 3. Maintenance Supervisor will monitor means of egress for barriers during the daily rounds. (ATTACHMENT A) 4. Administrator will monitor the work progress and completion during environmental rounds weekly and review through our Quality Assurance Program.</p>	01/20/2013			

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	<p>been cleared of snow and the lock on the gate could not be opened to allow resident, visitors and staff access to the public way.</p> <p>3.1-19(b)</p>			

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K0048 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to include the use of facility fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (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 <p>This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire disaster plan on 01/02/13 at 1:45 p.m. with the Maintenance Supervisor, the fire disaster plan did not include the use of either the ABC class fire extinguisher used throughout the facility or the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen</p>	K0048	<p>K048 Plan of Correction affects all residents, visitors and staff. 1. Maintenance Supervisor and Administrator reviewed the current policy on the use of the fire extinguishers. Provided clarification to include the types of extinguishers available and when to use them. (ATTACHMENT B) 2. The Administrator re-educated the Maintenance Supervisor and all staff on the policy changes, types of extinguishers and when to utilize. 3. Maintenance Supervisor will monitor disaster manual and keep updated on a quarterly basis AND as needed. 4. Administrator will monitor the work progress and completion and review through our Quality Assurance Program.</p>	01/20/2013			

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	<p>overhead extinguishing system. Based on an interview on 01/02/13 at 2:47 p.m. with the Maintenance Supervisor, it was acknowledged the written fire safety plan for the facility did not include mention of the ABC or K-class fire extinguishers.</p> <p>3.1-19(b)</p>			

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K0050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct fire drills on all shifts for 1 of 4 quarters for 2012. This deficient practice affects all residents in the facility including staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Monthly Fire Drill records on 01/02/13 at 2:15 p.m. with the Maintenance Supervisor, a fire drill report for the third shift of the fourth quarter of 2012 was not available for review. Based on interview on 01/02/13 at 2:17 p.m. with the Maintenance Supervisor, it was acknowledged the fire drill for the third shift of of the fourth quarter of 2012 had not been done.</p> <p>3.1-19(b) 3.1-51(c)</p>	K0050	<p>K050 Plan of Correction affects all residents in the facility including staff and visitors. 1. Maintenance Supervisor conducted a third shift fire drill to assure third shift inclusion as closely as possible to missed drill. (ATTACHMENT C) 2. Administrator re-educated maintenance staff on the regulation that fire drills are to be held at unexpected times under varying conditions, at least quarterly on each shift. 3. Maintenance Supervisor will conduct drills and monitor for compliance with NFPA 101 Life Safety Code Standard. 4. Administrator will monitor the work progress and completion on a monthly basis and review through our Quality Assurance Program.</p>	01/20/2013	

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K0051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/02/13 at 1:30</p>	K0051	K051 Plan of Correction affects all residents as well as visitors and staff. 1. The Maintenance Supervisor immediately marked the fire alarm circuit disconnecting means in RED to identify it as FIRE ALARM CIRCUIT CONTROL in accordance with NFPA 72, National Fire Alarm Code, 1999 edition. 2. The Administrator re-educated the new Maintenance Supervisor on the importance of having the fire alarm circuit disconnecting means marked in red to identify it as FIRE ALARM CIRCUIT CONTROL. 3. The Maintenance Supervisor will monitor the fire alarm circuit weekly during his	01/20/2013			

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	<p>p.m. with the Maintenance Supervisor, the fire alarm system circuit breaker located in the generator room on 100 hall did not have red marking nor was it identified as the Fire Alarm Circuit Control. Based on interview on 01/02/13 at 1:35 p.m. with the Maintenance Supervisor, it was acknowledged the fire alarm electrical breaker was not marked in red or properly identified.</p> <p>3.1-19(b)</p>		<p>rounds. (ATTACHMENT A) 4. The Administrator will monitor the work progress and completion during weekly environmental rounds and review through our Quality Assurance Program.</p>	

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K0061 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on record review and interview, the facility failed to electronically supervise 1 of 1 Post Indicator Valves (PIV) serving the entire facility. LSC Section 9.7.2.1 requires supervisory attachments to be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. This deficient practice could affect all residents as well as staff and visitors, if the water to the sprinkler system was shut off and not detected due to lack of supervision.</p> <p>Findings include:</p> <p>Based on review of quarterly Sprinkler Inspection Reports documentation with the Maintenance Supervisor at 2:20 p.m. on 01/03/13, the PIV lacked electronic supervision. Elwood Fire and Security performed quarterly sprinkler inspections as documented on quarterly sprinkler inspection reports dated 12/13/12, but they did not address whether a supervised signal for the PIV was present or not.</p>	K0061	<p>K061 Plan of Correction affects all residents, staff and visitors. 1. Elwood Fire will install and electronically supervise the facility Post Indicator Valve serving the entire facility. 2. The Administrator will review and re-educate the new Maintenance Supervisor on the need to have the P.I.V. electronically supervised to assure a distinctive signal is provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. 3. The Maintenance department will monitor the system daily during their rounds. 4. The Administrator will monitor work, progress and completion and review through our Quality Assurance Program.</p>	02/01/2013			

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	<p>Furthermore, the Maintenance Supervisor did not know a tamper switch was required for the PIV nor could he provide any further documentation to verify a tamper switch was present and relayed a signal to the fire panel. Based on a telephone interview with Elwood Fire and Security on 01/03/13 at 2:25 p.m. by the Maintenance Supervisor, it was acknowledged by Elwood Fire and Security the tamper switch and supervisory functions for the PIV could not be verified at this time.</p> <p>3.1-19(b)</p>			

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K0074 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation, record review and interview; the facility failed to ensure the window curtains in 1 of 35 resident rooms was maintained in a fire resistant condition. This deficient practice would mainly affect 2 residents in room # 117 as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/02/13 at 12:50 p.m. with the Maintenance Supervisor, the window curtains installed in resident # 117 lacked attached documentation confirming they were inherently flame resistant. Based on record review on 01/02/13 at 2:45 p.m.</p>	K0074	K074 Plan of Correction affects 2 residents of room #117, staff and visitors. 1. The Maintenance Supervisor removed the curtains that the family brought in and treated with a fire resistance. 2. Staff was educated on the need to keep a close eye on what families bring into the facility in order for maintenance to evaluate it for fire resistance rating and educate the families. 3. Maintenance Supervisor will monitor each room for compliance with daily rounds. 4. Administrator will monitor work progress, any redecorating, and completion during environmental rounds weekly and review through our Quality Assurance Program.	01/20/2013	

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	<p>with the Maintenance Supervisor, the aforementioned window curtains were not inherently flame resistant nor had a fire resistant solution ever been applied. Based on interview on 01/02/13 at 2:47 p.m. with the Maintenance Supervisor, it was acknowledged there was no documentation regarding the application of a flame resistance solution to the curtains.</p> <p>3.1-19(b)</p>			

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K0144 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>Based on record review and interview, the facility failed to document the alternate source of power from the generator was capable of automatically connecting to load within 10 seconds 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, 3-6.3.1.2 requires the emergency system to be arranged so, in the event of failure of the normal power source, the alternate source of power will automatically connect to load within 10 seconds. This deficient practice could affect all residents in the facility as well as visitors and staff since it could not be assured all residents were safeguarded with a generator which would operate under load conditions when needed during a power failure.</p> <p>Findings include:</p> <p>Based on review of Generator Log records on 01/02/13 at 2:30 p.m. with the Maintenance Supervisor, the number of seconds for the generator to transfer load</p>	K0144	<p>K144 Plan of Correction affects all residents in the facility as well as visitors and staff. 1. Generator company provided the appropriate form (ATTACHMENT E-F) along with instruction. Apparently, the Maintenance Supervisor had been running on full load with each testing but not the amount of time to switch over. This has been corrected. 2. Administrator re-educated all maintenance staff on importance of complete and accurate documentation of time taken to switch to full load. 3. The Maintenance Supervisor will monitor the system weekly with rounds. 4. The Administrator will monitor work progress and completion and review through our Quality Assurance Program.</p>	01/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155521	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/02/2013
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	<p>was not documented. Based on interview on 01/02/13 at 2:33 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>			