

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155651	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/02/2014
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NAME OF PROVIDER OR SUPPLIER HOMEVIEW CENTER OF FRANKLIN	STREET ADDRESS, CITY, STATE, ZIP CODE 651 S STATE ST FRANKLIN, IN 46131
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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: 07/02/14</p> <p>Facility Number: 000353 Provider Number: 155651 AIM Number: 100291330</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Homeview Center of Franklin 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) and 410 IAC 16.2. The original building consisting of the 100, 200, 400 and 600 Halls was surveyed with Chapter 19 Existing Health Care Occupancies.</p> <p>This one story facility consists of two sections: the original building built in 1985 determined to be of Type V (111) construction was fully sprinklered, except for closets in the 100 and 200 Hall, and</p>	K010000		

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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K010038	<p>NFPA 101</p> <p>the New Wing addition added to the south of the original building in 2005, of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and hard wired smoke detectors in resident sleeping rooms. The facility has a capacity of 115 and had a census of 105 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered except for the closets in the 100 and 200 Hall. The facility has one detached building providing facility services which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/14/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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SS=E	<p>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 3 of 14 exit door electromagnetic locks remained unlocked while the fire alarm was activated. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.2(e) states activation of the building automatic sprinkler or fire detection system, if provided, automatically unlocks the doors and the doors remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice could affect 30 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:15 p.m. on 07/02/14, the electromagnetic lock on the facility exit to the exterior of the building by Room 212 and the two sets of cross corridor doors' electromagnetic locks by Dining Room # 2 did not remain unlocked when the fire alarm was activated at 1:44 p.m. After activation of the fire alarm system at 1:44 p.m. and subsequent silencing of</p>	K010038	<p>Facility requests paper compliance for the deficiency.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and continue to provide quality care in a safe environment.</p> <p>K38</p> <p>1) Immediate action taken for issue identified: Facility utilized services of a certified fire alarm tech to perform the inspection and repair on the delayed egress door system. The exit door in Dining Room #3 was inspected and repaired to operate properly within the 15 second period.</p> <p>2) How the facility identified other potential areas: All delayed egress doors were inspected and tested. Every door opened within 15 second period just as posted signage on the doors instructs. No other areas were affected.</p> <p>3) Measures put into place: The Certified Fire Alarm Tech reprogrammed the egress doors. The doors have been tested multiple times and the door opens within 15</p>	07/25/2014			

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K010056 SS=E	<p>the system, all electromagnetic locks in the building remained unlocked except at the three aforementioned locations. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned electromagnetic locks did not remain unlocked while the fire alarm system was activated.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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>1. Based on observation and interview, the facility failed to ensure a sprinkler was installed in 23 of 57 resident sleeping room closets to provide</p>	K010056	<p>seconds.</p> <p>4) How the corrective actions will be monitored: Maintenance shall monitor all delayed egress door systems on a monthly basis as set up in the TELS Program. This audit will be logged monthly. Results will be reviewed in the monthly QA x6 months and as needed thereafter.</p> <p>5) Who is responsible for monitoring: Administrator/Designee</p> <p>6) Date of Compliance: July 11, 2014</p> <p>Facility requests paper compliance for the deficiency. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists.</p>	08/04/2014			

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	<p>coverage for all portions of the building. This deficient practice could affect 46 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:15 p.m. on 07/02/14, wardrobe units affixed to the wall from the floor to the ceiling were not sprinklered in resident sleeping rooms 101, 102, 103, 104, 105, 106, 107, 108, 111, 113, 114, 115, 116, 117, 118, 207, 208, 209, 210, 211, 212, 213 and 215. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned closets were not provided with a sprinkler heads.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>2. Based on observation and interview, the facility failed to ensure the sprinkler system was installed in accordance with 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</p>		<p>This plan of correction is provided as evidence of the facility's desire to comply with the regulations and continue to provide quality care in a safe environment.</p> <p>K56</p> <p>1) Immediate actions take for those residents identified: The 20 room closets identified in resident rooms: 113, 114, 117, 118, 208, 209, 211, 212, 213, and 215 all have full sprinkler coverage for the entire room including the closets. SafeCare Sprinkler Division has audited each room and has stated the sprinkler coverage is complete including the resident room closets. This inspection and professional assessment is written on Safe Care letter head and will be retain in our file. Room 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 115, 116, 207 and 210, Homeview will relocate these existing sprinkler heads to conform to NFPA-13 which then will provide full sprinkler coverage as well.</p> <p>In Rooms 202 and 204, SafeCare Sprinkler Division installed arm over support brackets.</p> <p>2) How the facility identified other residents: SafeCare Sprinkler Division conducted a full resident room audit. The 31 resident room closets in 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 115, 116, 207 and 210 will have sprinkler</p>				

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K010144 SS=E	<p>inches for copper tube. This deficient practice could affect 30 residents, staff and visitors in the 200 Hall.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:15 p.m. on 07/02/14, a six foot horizontal length of steel sprinkler pipe installed in Room 202 and a thirty one inch horizontal length of steel sprinkler pipe in Room 204 were each an unsupported armover to a sprinkler. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned sprinkler locations had an unsupported armover greater than 24 inches in length for a steel pipe.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per</p>		<p>heads relocated on 8/4/14 which will have full closet coverage.</p> <p>After inspection of the entire facility only two areas in the center had a sprinkler pipe without an arm over bracket. This was installed and no other areas were identified.</p> <p>3) Measure put into place/system change: The letter from SafeCare certifying that Homeview has full sprinkler coverage including the closets will be kept on file in our Life Safety binder.</p> <p>No other sprinkler work or construction is planned at this time.</p> <p>4) How the corrective actions will be monitored: The Maintenance Supervisor will inspect each sprinkler relocation. The arm over brackets has been inspected and meets the regulation requirements of this code.</p> <p>5) Who is responsible for monitoring: Administrator/Designee</p> <p>6) Date of Compliance: August 4, 2014</p>				

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	<p>month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 generators was in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. In addition, NFPA 101 at Section 4.6.12.1 requires that any device, equipment or system required for compliance with this Code shall be continuously maintained. This deficient practice could affect 68 of 115 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:15 p.m. on 07/02/14, the facility has two generators to supply the building with emergency power. Emergency generator # 1 supplies emergency power to the existing part of the building. The remote annunciator for emergency generator #1 is located at Nurses Station # 1 and failed to operate when the annunciator test button was pressed five times. In addition, the remote annunciator failed to indicate the</p>	K010144	<p>Facility requests paper compliance for the deficiency.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and continue to provide quality care in a safe environment.</p> <p>K144</p> <p>1) Immediate action taken for identified area: The facility arranged to have the remote annunciator replaced by a Certified Emergency Generator technician. The remote annunciator now operates properly to indicate that emergency generator #1 is operating when emergency power is being transferred.</p> <p>2) How the facility identified other potential areas: Generator #2 annunciator was tested and fully functioning.</p> <p>3) Measures put into place/system change: A new annunciator panel was installed.</p> <p>4) How the Corrective Action will be monitored: The Maintenance Supervisor or Designee will perform weekly Generator test x 4 and then monthly.</p>	08/04/2014

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K020000	<p>emergency power source is operating when emergency generator # 1 was operated to transfer power at 12:58 p.m. Based on interview at the time of observation, the Maintenance Director acknowledged the remote annunciator for emergency generator # 1 located at Nurses Station # 1 was inoperable.</p> <p>3.1-19(b)</p> <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: 07/02/14</p> <p>Facility Number: 000353 Provider Number: 155651 AIM Number: 100291330</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Homeview Center of Franklin was found</p>	K020000	<p>Maintenance/Designee will monitor the remote annunciators on a monthly basis set up in the TELS Program to assure proper operations.</p> <p>The audits will be reviewed in monthly QA x 6 months and as needed thereafter.</p> <p>5) Who is responsible for monitoring: Administrator/Designee</p> <p>6) Date of Compliance: August 4, 2014</p>				

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	<p>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) and 410 IAC 16.2. The 300 Hall built in 2005 and Rehabilitation Room addition were surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility consists of two sections: the original building built in 1985 was determined to be of Type V (111) construction was fully sprinklered, except for closets in the 100 and 200 Hall, and the New Wing addition added to the south of the original building in 2005 is of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and hard wired smoke detectors in resident sleeping rooms. The facility has a capacity of 115 and had a census of 105 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered except for the closets in the 100 and 200 Hall. The facility has one detached building providing facility services which was not sprinklered.</p> <p>The facility was found not in compliance</p>						

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K020038 SS=E	<p>with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 6 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor</p>	K020038	<p>Facility requests paper compliance for the deficiency.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and continue to provide quality care in a safe environment.</p> <p>K38</p> <p>1) Immediate action taken for issue identified: Facility utilized services of a certified fire alarm tech to perform the inspection and repair on the delayed egress door system. The exit door in Dining Room #3 was inspected and repaired to operate properly within the 15 second period.</p> <p>2) How the facility identified other potential areas: All delayed egress doors were</p>	07/11/2014

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	<p>required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS.</p> <p>This deficient practice could affect 42 residents, staff and visitors in Dining Room # 3.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:15 p.m. on 07/02/14, the exit door in Dining Room # 3 to the exterior of the building is marked as a facility exit, is equipped with a delayed egress lock and is provided with necessary signage stating the door could</p>		<p>inspected and tested. Every door opened within 15 second period just as posted signage on the doors instructs. No other areas were affected.</p> <p>3) Measures put into place: The Certified Fire Alarm Tech reprogrammed the egress doors. The doors have been tested multiple times and the door opens within 15 seconds.</p> <p>4) How the corrective actions will be monitored: Maintenance shall monitor all delayed egress door systems on a monthly basis as set up in the TELS Program. This audit will be logged monthly. Results will be reviewed in the monthly QA x6 months and as needed thereafter.</p> <p>5) Who is responsible for monitoring: Administrator/Designee</p> <p>6) Date of Compliance: July 11, 2014</p>				

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	<p>be opened in 15 seconds by pushing on the door release device but the door did not release until 29 seconds had lapsed when the door was pushed with the application of force two separate times. Based on interview at the time of observation, the Administrator stated the aforementioned exit door is a facility exit, is equipped with a delayed egress lock, the exit door is set to release within 30 seconds with the application of force because the area is not under constant supervision and acknowledged the exit door in Dining Room # 3 to the exterior of the building did not release within the posted 15 seconds when pushed with the application of force.</p> <p>3.1-19(b)</p>				