

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155815	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/02/2015
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NAME OF PROVIDER OR SUPPLIER CLEARVISTA LAKE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256
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K 000 Bldg. 01	<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: 03/02/15</p> <p>Facility Number: 013019 Provider Number: 155815 AIM Number: 201251520</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Clearvista Lake Health Campus was found not in compliance with Requirements for Participation 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 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility, located on the first floor of a two story building, was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the</p>	K 000		

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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K 034 SS=E Bldg. 01	<p>corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 70 and had a census of 49 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/05/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 18.2.2.4 Based on observation and interview, the facility failed to ensure items stored in 1 of 3 interior fire escape stairways would not interfere with egress. LSC 7.2.2.5.3 requires usable space within an exit enclosure, including under stairs, or any open space within the enclosure shall not be used for any other purpose which could interfere with egress. This</p>	K 034	K0034 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: No Residents, visitors, or staff were effected by the alleged deficiency. Identification of other residents having the potential to be effected by the alleged deficient practice: No other residents had the potential to be effected by the	04/01/2015

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K 050 SS=F Bldg. 01	<p>deficient practice could affect 27 residents, visitors and staff using the exit stairwell on the first floor by the elevator for evacuation.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations during a tour of the facility from 11:45 a.m. to 1:30 p.m. on 03/02/15, the exit stairwell on the first floor by the elevator which was marked as a first floor exit was used to store three mattresses and portable toilet seat stands which were stacked on top of one another. Based on interview at the time of observation, the Director of Plant Operations acknowledged the exit stairwell on the first floor by the elevator was used to store three mattresses and portable toilet seats which could interfere with egress.</p> <p>3.1-19(b)</p> <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</p>		<p>alleged deficient practice. Measures put into place and systemic changes made to ensure that the alleged deficient practice does not reoccur: Director of Plant Operations removed all Durable Medical Equipment from the stairwell. Per LSC 7.2.2.5.3, facility will no longer store equipment in facility stairwells. How the corrective measures will be monitored to ensure that the alleged deficient practice does not reoccur: The Director of Plant Operations/Designee will conduct facility rounds daily to ensure that no equipment is stored in facility stairwells. Rounds will be conducted daily times 4 weeks and then weekly times 2 months. Results will be reported to QA monthly. See attachment A for audit tool.</p>	

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	<p>announcement may be used instead of audible alarms. 18.7.1.2</p> <p>1. Based on record review and interview, the facility failed to document fire drills on the second shift for 1 of 4 calendar quarters. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Record" and "Record of Drills: Fire" documentation with the Director of Plant Operations during record review from 9:20 a.m. to 11:45 a.m. on 03/02/15, documentation of a fire drill conducted on the second shift in the fourth quarter (October, November, December) of 2014 was not available for review. Based on interview at the time of record review, the Director of Plant Operations acknowledged documentation of a fire drill conducted on the second shift in the fourth quarter (October, November, and December) of 2014 was not available for review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to document activation of the fire alarm system for first shift fire drills conducted between 6:00 a.m. and</p>	K 050	<p>K0050 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: 1. No Residents, visitors, or staff were effected by the alleged deficiency. 2. No Residents, visitors, or staff were effected by the alleged deficiency. Identification of other residents having the potential to be effected by the alleged deficient practice: 1. All potential residents, visitors, and/or staff had the potential to be effected by the alleged deficient practice. 2. All potential residents, visitors, and/or staff had the potential to be effected by the alleged deficient practice. Measures put into place and systemic changes made to ensure that the alleged deficient practice does not reoccur: 1. Per regulation, Director of Plant Operations will successfully complete one fire drill per shift per quarter and be able to provide documentation of such upon request. 2. Per regulation, Director of Plant Operations will ensure that all fire drills conducted will include the activation of the fire alarm system and the transmission of the fire alarm signal. How the corrective measures will be monitored to ensure that the alleged deficient practice does not reoccur: 1. Facility Executive Director/Designee will monitor the</p>	04/01/2015

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	<p>9:00 p.m. for 2 of 4 quarters. LSC 18.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Record" and "Record of Drills: Fire" documentation with the Director of Plant Operations during record review from 9:20 a.m. to 11:45 a.m. on 03/02/15, documentation for the first shift fire drill conducted on 04/23/14 at 9:45 a.m. and the first shift fire drill conducted on 07/14/14 at 1:00 p.m. indicated each drill was conducted after 6:00 a.m. but before 9:00 p.m. and did not include activation of the fire alarm system and transmission of the fire alarm signal. Based on interview at the time of record review, the Director of Plant Operations acknowledged documentation for the aforementioned first shift fire drills conducted after 6:00 a.m. but before 9:00 p.m. did not include activation of the fire</p>		<p>completion of fire drills per regulation; one per shift per quarter. Auditing of the fire drills will be conducted monthly times 6 months. 2. Facility Executive Director/Designee will monitor the completion of fire drills per regulation; ensuring that the fire alarm signal is transmitted for all fire drills conducted between the hours of 9AM-6PM. Auditing of the fire drills will be conducted monthly times 6 months. See attachment B for audit tool.</p>	

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K 052 SS=F Bldg. 01	<p>alarm system and transmission of the fire alarm signal.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>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</p> <p>Based on record review and interview, the facility failed to document annual functional testing of all fire alarm system smoke detectors and duct detectors. NFPA 72, 7-3.2 refers to fire alarm component testing frequencies in Table 7-3.2 which requires an annual functional test of smoke detector initiating devices. Section 7-5.2 requires a permanent record of all inspections, testing and maintenance shall be provided that includes information requested in Figure 7-5.2.2. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Vanguard Alarm Services "Periodic Fire Alarm Inspection and Testing Report" documentation dated 03/25/14, 06/18/14, 09/23/14 and</p>	K 052	<p>K0052 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: No Residents, visitors, or staff were effected by the alleged deficiency. Identification of other residents having the potential to be effected by the alleged deficient practice: All potential residents, visitors, or staff had the potential to be effected by the alleged deficient practice. Measures put into place and systemic changes made to ensure that the alleged deficient practice does not reoccur: Facility will have on site at all times, documentation of all functional testing conducted on all fire alarm system detectors and duct detectors. How the corrective measures will be monitored to ensure that the alleged deficient practice does not reoccur: Facility Director of Plant Operations/Designee will</p>	04/01/2015

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K 072 SS=E Bldg. 01	<p>12/31/14 with the Director of Plant Operations during record review from 9:20 a.m. to 11:45 a.m. on 03/02/15, documentation of annual functional testing of all fire alarm system smoke detectors and duct detectors within the last twelve month period was not available for review. Review of the 06/18/14 quarterly fire alarm system inspection documentation indicated there are 98 smoke detectors and five duct detectors located in the building on the first floor. Based on interview at the time of record review, the Director of Plant Operations stated no additional fire alarm system inspection reports for the last year was available for review and acknowledged documentation of annual functional testing for all fire alarm system smoke detectors and duct detectors within the last twelve month period was not available for review.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure the means of</p>	K 072	audit documentation to ensure that functional testing conducted on fire alarm systems is available at all times. Auditing will be conducted quarterly times 2 quarters. See attachment C for audit tool.	04/01/2015			
			K0072 Corrective Actions accomplished for those residents				

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	<p>egress was continuously maintained free of all obstructions or impediments to full instant use for 1 of 10 exits. This deficient practice could affect 20 residents, staff and visitors if needing to exit the building from the service hall exit.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations at 9:00 a.m. and during a tour of the facility from 11:45 a.m. to 1:30 p.m. on 03/02/15, the service hall is marked as a facility exit and a portable buffet cart, food cart and a three shelf table were being stored in the corridor which failed to ensure the means of egress in the service hall was continuously maintained free of all obstructions or impediments to full instant use. Based on interview at the time of the observation, the Director of Plant Operations stated the portable buffet cart is used a couple of times per week but is stored in the service hall when not in use and acknowledged the service hall is marked as a facility exit and a portable buffet cart, food cart and a three shelf table were being stored in the corridor</p> <p>3.1-19(b)</p>		<p>found to have been affected by the alleged deficient practice: No Residents, visitors, or staff were effected by the alleged deficiency. Identification of other residents having the potential to be effected by the alleged deficient practice: No other residents had the potential to be effected by the alleged deficient practice. Measures put into place and systemic changes made to ensure that the alleged deficient practice does not reoccur: Director of Plant Operations removed all Equipment from the corridor. Per Life Safety Code, the facility will not store items in corridors labeled as exits from the building. How the corrective measures will be monitored to ensure that the alleged deficient practice does not reoccur: The Director of Plant Operations/Designee will conduct facility rounds daily to ensure that no equipment is stored in corridors marked as exits from the facility. Rounds will be conducted daily times 4 weeks and then weekly times 2 months. Results will be reported to QA monthly. See attachment D for audit tool.</p>		

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K 144 SS=C Bldg. 01	<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 ensure a monthly load test for the emergency generator was conducted for 12 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, 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. NFPA 99,</p>	K 144	<p>K0144 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: No Residents, visitors, or staff were effected by the alleged deficiency. Identification of other residents having the potential to be effected by the alleged deficient practice: All residents, visitors, and/or staff have the potential to be effected by the alleged deficient practice. Measures put into place and systemic changes made to ensure that the alleged deficient practice does not reoccur: Director of Plant Operations will ensure that the load bank test is conducted properly by purchasing a thermometer to measure the exhaust temperature of the generator during a load test per manufacturers guidelines. How the corrective measures will be monitored to ensure that the alleged deficient practice does not reoccur: Facility Executive Director/Designee will audit generator load bank testing to ensure compliance per manufacturers guidelines. Auditing will occur monthly times 6 months. See attachment E for audit tool.</p>	04/01/2015

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	<p>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.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator Weekly Load Test" documentation with the Director of Plant Operations during record review from 9:20 a.m. to 11:45 a.m. on 03/02/15, generator load test documentation for the twelve month period of March 2014 through February 2015 did not record the load test percentage of the Emergency Power Supply (EPS) nameplate rating. In addition, each of the aforementioned load tests did not document the test was under operating temperature conditions or at loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>Based on interview at the time of record review, the Director of Plant Operations stated the emergency generator was load tested during the aforementioned period but acknowledged monthly generator load test documentation for the twelve month period of March 2014 through February 2015 did not record the load test</p>			

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	percentage or document the testing was under operating temperature conditions or at loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. 3.1-19(b)			