STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155521	A. BUILDING -- B. WING	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALEXANDRIA CARE CENTER	1912 S PARK AVE ALEXANDRIA, IN 46001

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/21/22 Facility Number: 000518 Provider Number: 155521 AIM Number: 100266670 At this Emergency Preparedness survey, Alexandria Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 70 certified beds. At the time of the survey, the census was 41. Quality Review completed on 09/26/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/21/22 Facility Number: 000518 Provider Number: 155521 AIM Number: 100266670 At this Life Safety Code survey, Alexandria Care Center was found not in compliance with	K 0000		

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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, spaces open to the corridors, and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 70 and had a census of 41 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one detached garage which was not sprinklered. Quality Review completed on 09/26/22			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 1. Based on record review, observation and interview; the facility failed to document annual testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by	K 0291	K291 1a. No residents were affected by this alleged deficient practice however over 15 residents and staff have the potential to be affected. 1b. No residents were affected by this alleged deficient practice	10/03/2022

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	7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) 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 over 15 residents and staff. Findings include: Based on record review and interview with the Administrator, Administrator in Training and Corporate Maintenance Professional on 09/21/22 between 10:45 a.m. and 1 p.m., annual 90-minute testing documentation for all battery backup lights was not available for review. Monthly and annual testing documentation was available but the 90-minute test was not indicated on the documentation for the two most recent years. The Corporate Maintenance Professional stated annual 90-minute testing documentation for the battery backup lights could not be deduced from the documentation provided. The finding was acknowledged by the Corporate Maintenance Professional at the time of discovery and again at the exit conference with the Administrator, Administrator in Training and Corporate Maintenance Professional all present. 2. Based on interview and observation, it was determined that the facility failed to provide		however everyone in the facility has the potential to be affected. 2a. The 90-minute testing documentation for all battery backup lights for the two most recent years was located after exit. All functional testing has been completed and is documented accordingly. 2b. The exterior lights at each facility exit have been connected to the generator to ensure exit lighting will illuminate in the event of a power outage. 3.The facility's preventative maintenance program has been reviewed with no required changes at this time. The Maintenance Director has been re-educated regarding ensuring annual testing for all battery backup lights are documented and stored in the facility preventative maintenance binder upon completion 4. The Maintenance Director or designee will be responsible for implementing a monitoring tool to ensure testing for battery backup lights are completed per LSC and exterior emergency lighting is provided at all exits. Monitoring will be done on a monthly basis through the facility's preventative maintenance program. Should a concern be found, immediate corrective action will occur.	

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	exterior emergency lighting for all exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all occupants in the facility including staff, visitors and residents if the facility were required to evacuate in an emergency and the generator was providing electricity at that time. This deficient practice could affect everyone in the facility. Findings include: Based on observations and interview during a tour of the facility with the Administrator in Training and Corporate Maintenance Professional on 09/21/22 between 1:00 p.m. and 3:45 p.m., the Corporate Maintenance Professional stated that the exterior lights for the exit discharge for all of the facility exits were not connected to the generator and that they were aware of the issue and were currently seeking resolve so the facilities exit lighting could illuminate in the event of a power outage. The finding was acknowledged by the Corporate Maintenance Professional at the time of discovery and again at the exit conference with the Administrator, Administrator in Training and Corporate Maintenance Professional all present. 3.1-19(b)		Results of these reviews and any corrective actions will be discussed during the monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of the audits will be increased or decreased according to the findings.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling			

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	to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfilling rooms had sufficient space in which to accomplish the procedure. NFPA 99, Health Care Facilities Code, 2012 edition, Section 11.5.2.3.1 (2) requires oxygen transfilling rooms to have adequate space, be mechanically ventilated, sprinklered and have ceramic or concrete flooring. This deficient practice could affect 15. Findings include: Based on observations and interview during a tour of the facility with the Administrator in Training and Corporate Maintenance Professional on 09/21/22 between 1:00 p.m. and 3:45 p.m., the oxygen storage/transfilling room did not have adequate space which made it impossible to trans fill oxygen with the door in the closed position. The available Respiratory Therapist, when asked to demonstrate how oxygen was transferred, stood with the door propped open with her foot to simulate the process. The Respiratory Therapist, when asked if this is how most people in the facility preform this procedure stated, yes. The finding was acknowledged by the Corporate Maintenance Professional at the time of discovery and again at the exit conference with the Administrator, Administrator in Training and Corporate Maintenance Professional all present. 3.1-19(b)	K 0927	**K297** 3. The facility's preventative maintenance program has been reviewed with no required changes at this time. The Maintenance Director and Respiratory Department has been re-educated regarding ensuring sufficient space is provided in the transfilling room. 4. The Maintenance Director or designee will be responsible for implementing a monitoring tool to ensure adequate space is provided for the trans fill of oxygen with the door in a closed position. The monitoring will occur once weekly for four weeks, and then monthly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of the audits will be increased or decreased according to the findings.	10/03/2022

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