STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155857	A. BUILDING -- B. WING	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANQUILITY NURSING AND REHAB	3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED 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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/07/21 Facility Number: 014265 Provider Number: 155857 AIM Number: 300029339 At this Emergency Preparedness survey, Tranquility Nursing and Rehab was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 78 certified beds. At the time of the survey, the census was 25. Quality Review completed on 09/13/21 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0031 SS=F Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 482.15(c)(2), 483.475(c)(2), 483.73(c)(2), 484.102(c)(2), 485.625(c)(2), 485.68(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2) Emergency Officials Contact Information §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2).			

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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	[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency.			
	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan included all applicable sources of assistance. This deficient practice could affect all occupants. Findings include:	E 0031	The Emergency Preparedness manual has been updated with the telephone number and portal access information for proper notification during an emergency. All manuals have been reviewed	10/04/2021

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	Based on review of "Emergency Preparedness Manual" documentation dated 08/09/21 with the Maintenance Director during record review from 8:55 a.m. to 12:10 p.m. on 09/07/21, the emergency preparedness plan did not include contacting the Indiana Department of Health (IDOH) by telephone at 317-460-7287 for emergency incidents that require a full or partial evacuation other than in the "Emergency Procedure-Fire Watch" section of the Manual. Based on interview at the time of record review, the Maintenance Director agreed the plan did not include the correct telephone contact information for the aforementioned emergency preparedness source of assistance for emergency incidents that require a full or partial evacuation. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.		for Emergency Preparedness and Life Safety to ensure that notification information is available and current. No new issues noted. The manuals will be reviewed quarterly to verify that contact information is available and current. The results of the reviews will be report to QA on a quarterly basis to ensure continue compliance. Quarterly reporting to the QA Team will continue until problem is considered resolved.	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]			

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	(1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the			

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	updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated			

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	policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.			

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	*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.			
	Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The LTC facility must do all of the	E 0037	The facility has initiated training for all staff through Relias for Emergency Preparedness training.	10/04/2021

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	following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Manual" documentation dated 08/09/21 with the Maintenance Director during record review from 8:55 a.m. to 12:10 p.m. on 09/07/21, documentation for staff training on emergency preparedness within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated staff training on emergency preparedness is done on computer and is documented in "Relias" on-line training but due to the recent change in ownership of the facility access to Relias is no longer available and agreed staff training documentation on the emergency preparedness program conducted within the most recent twelve month period was not available for review at the time of the survey. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.		All training through Relias has been initiated for all areas of training including Emergency Preparedness. Training has initiated for all staff. Relias training progress will be reported to the Administrator, Director of Maintenance or designee. Results of training will be reported to the QA Team to ensure continued compliance.	
K 0000 Bldg. 01	A Life Safety Code Certification and State	K 0000		

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	Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/07/21 Facility Number: 014265 Provider Number: 155857 AIM Number: 300029339 At this Life Safety Code survey, Tranquility Nursing and Rehab was found not in compliance with 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 (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor with smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 78 and had a census of 25 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 storage building. Quality Review completed on 09/13/21			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating			

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	(with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	1. Based on observation and interview, the facility failed to ensure 2 of over 5 hazardous areas such as soiled linen and trash collection rooms (exceeding 64 gallons) and laundries (larger than 100 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors.	K 0321	The areas cited during the survey have been corrected. The 8-inch hole in the soiled utility room by the north nurses' station has been patched with fire stop. The holes in the east wall of the soiled utility room have been patched and repaired. Annular space around the 4 fire vents in the laundry room have been patched, repaired and	10/04/2021

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 1:50 p.m. on 09/07/21, the following was noted: a. an eight inch square hole was noted in the ceiling of the Soiled Utility Room by the north nurse's station for the passage of one red water line and one blue water line. b. several holes were noted in the east wall of the Soiled Utility Room by the north nurse's station. The holes were noted near the floor around the capped water lines. c. the annular space surrounding four dryer vents which penetrated the Laundry Room ceiling behind the dryers was not firestopped. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned hazardous areas were not separated from other spaces by smoke resistant partitions. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 5 hazardous areas such as combustible storage rooms (over 50 square feet in size) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the former training room near the main entrance lobby.		fire stop applied. Automatic closure has been applied to the supply room door. The Regional Maintenance Director has made rounds in the facility to identify other areas that may be effected by the deficiency. Additional areas identified during rounds have been corrected. Conduit identified in the clean utility was caulked / fire stopped. Rounds will be conducted by the Maintenance Director or designee on a monthly basis to identify any other issues related to this deficient practice. Director or designee will reporting finding the Administrator and Regional Director for review and verification of repair. Results of rounds will be reported to the QA Team at least monthly to ensure continued compliance or until problem is considered resolved.	

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 1:50 p.m. on 09/07/21, the former training room near the main entrance lobby was converted to a storage room containing shelf storage of combustible supplies and boxes. The room was greater than 50 square feet in size. The corridor door to the room was not self closing or automatic closing. Based on interview at the time of the observations, the Maintenance Director stated the room had been a training room but was converted to a storage room for supplies and agreed the room was greater than 50 square feet in size and the corridor door was not self closing or automatic closing. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or			

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	* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	Based on record review and interview, the facility failed to ensure 1 of 1 kitchen range hood exhaust system was maintained in proper working order. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition, Section 7.8.2.1(8) requires rooftop terminations to be arranged with or provided with a hinged upblast fan supplied with flexible weatherproof electrical cable and service hold-open retainer to permit inspection and cleaning that is listed for commercial cooking equipment. This deficient practice was not in a resident area but could affect over two kitchen staff. Findings include: Based on review of the kitchen range hood system inspection contractor's "Job Summary" and e-mail documentation dated 03/10/21 with the Maintenance Director during record review from 8:55 a.m. to 12:10 p.m. on 09/07/21, the kitchen range hood system is in need of a hinge kit. The aforementioned documentation stated "the next cleaning in September we will be installing a hinge kit to get up to the NFPA 96 fire code". Based on interview at the time of record review, the Maintenance Director stated the hinge kit had not yet been installed and would be installed on the next contractor visit scheduled for September 2021.	K 0324	The kitchen was serviced in September per our conversation with the surveyor. The hinge kit system that was scheduled for install during the month of September was the not the appropriate hinge kit. A new one has been ordered and is now scheduled for install before 10/15/2021. No other areas can be effected by this deficient practice. The hinge kit has been added to the range hood preventative maintenance which is scheduled for quarterly review. Results of range hood evaluation will be reported to the QA Team at least quarterly for continued monitoring or until problem is considered resolved.	10/15/2021

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TRANQUILITY NURSING AND REHAB	3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205

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	This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6			
	Based on record review and interview, the facility failed to provide a complete written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out-of-service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Emergency Preparedness Manual: Emergency Procedure - Fire Watch" documentation dated 08/09/21 with the Maintenance Director during record review from 8:55 a.m. to 12:10 p.m. on 09/07/21, the fire watch plan for fire alarm system impairment was incomplete. The plan did not expressly state when a fire watch would be initiated. The plan did not state when the required fire alarm system is out-of-service for more than 4 hours in a 24-hour	K 0346	The Fire Watch has been updated to included the reasons that a fire watch would be initiated. The reasons add are that the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period and/or if the sprinkler system has to be placed out of service for 10 hours or more in a 24 hour period. Other Policies have been reviewed by the Regional Director of Maintenance to ensure that this deficient practice does not effect other policies. No new issue noted. Policies will be reviewed by the Maintenance Director or designee at least quarterly to ensure	10/04/2021

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	period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. Based on interview at the time of record review, the Maintenance Director agreed fire watch documentation for fire alarm system impairment did not expressly state when a fire watch for fire alarm system impairment would be initiated. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		continued compliance. Results of review will be reported to the QA Team to ensure continued compliance until the problem is considered resolved or until problem is resolved.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on record review and interview, the facility failed to ensure a full hydrostatic flush was	K 0353	Items cited during the survey have been corrected. The fire sprinkler	10/18/2021

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	performed on 1 of 1 automatic sprinkler piping systems that were internally inspected as required by NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems in Chapter 14, Obstruction Prevention. Section 14.3.2 requires systems shall be examined for internal obstructions where conditions exist that could cause obstructed piping. Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient material to obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified personnel. Section 14.3.1 states if the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the sprinkler system inspection contractor's "Inspection & Test Report" documentation dated 03/08/21 with the Maintenance Director during record review from 8:55 a.m. to 12:10 p.m. on 09/07/21, the facility's dry pipe sprinkler system is in need of the five year internal pipe inspection. The contractor's report stated "recommend 5 yr Internal Pipe Inspection". Review of the sprinkler system inspection contractor's "Sprinkler: Five Year Internal Pipe Inspection" documentation dated 08/05/21 indicated the facility has one dry pipe sprinkler system and "system needs flushed". Based on interview at the time of record review, the Maintenance Director stated the contractor provided a quote on 09/01/21 to flush the sprinkler		protection is still scheduled for flushing on 10/18/2021 per the conversation with the Surveyor and with SafeCare. The weekly audits have been updated to include sprinkle gage. The blue bundle of cords was removed from the horizontal sprinkler pipe. Regional Maintenance Director has reviewed the weekly preventative log. Rounds have been completed with no findings for cords attached to the sprinkler pipes. The policy has been updated to reflect that sprinkler pipe flushing needs to be completed upon inspection at least every 5 years. The weekly audit tool has been updated and reviewed by the Regional Maintenance Director to ensure all areas of concern are included. Attic assessible area will be inspected quarterly including pipes are free of any attachments or obstructions. The results of the audits will be reported to the QA team at least quarterly to ensure continued compliance or until problem is considered resolved.	

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system and the quote was approved by the facility on 09/07/21 as documented on "Quote q39122" documentation dated 09/01/21. Based on interview at the time of record review, the Maintenance Director agreed the system flush has not yet been scheduled but they were actively working with the contractor to schedule the flush as soon as possible.

This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.

3-1.19(b)

2. Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1 states all valves shall be inspected weekly. Section 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Section 13.3.2.2 states the valve inspection shall verify that the valves are in the following condition:
(1) In the normal open or closed position
(2) *Sealed , locked or supervised
(3) Accessible
(4) Provided with correct wrenches
(5) Free from external leaks
(6) Provided with applicable identification
Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request.

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	This deficient practice could affect all residents and staff in the facility. Findings include: Based on review of "Automatic Sprinkler Pressure Gauge Inspection" documentation with the Maintenance Director during record review from 8:55 a.m. to 12:10 p.m. on 09/07/21, monthly sprinkler system valve inspection documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated he inspects sprinkler system valves on a weekly basis as part of the sprinkler gauge inspection but the valve inspections are not documented. Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 1:50 p.m. on 09/07/21, the facility has a supervised dry sprinkler system. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3-1.19(b) 3. Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler systems in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect all residents, staff and visitors.			

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 1:50 p.m. on 09/07/21, bundled blue data cables were affixed to a ten foot section of horizontal sprinkler pipe with electrician's tape in the attic above the attic access door in the main entrance lobby above the reception desk. Based on interview at the time of the observations, the Maintenance Director agreed sprinkler piping was used to support nonsystem components in the attic above the main entrance lobby. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy	K 0354	The Fire Watch has been updated to included the reasons that a fire	10/04/2021

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	containing procedures to be followed for the protection of all residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25. NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Emergency Preparedness Manual: Emergency Procedure - Fire Watch" documentation dated 08/09/21 with the Maintenance Director during record review from 8:55 a.m. to 12:10 p.m. on 09/07/21, the fire watch plan for sprinkler system impairment was incomplete. The plan did not expressly state when a fire watch would be initiated. The plan did not state when the required sprinkler system is out-of-service for 10 hours or more in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. Based on interview at the time of record review, the Maintenance Director agreed fire watch documentation for sprinkler system impairment did not expressly state when a fire watch for sprinkler system impairment would be initiated. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.		watch would be initiated. The reasons add are that the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period and/or if the sprinkler system has to be placed out of service for 10 hours or more in a 24 hour period. Other Policies have been reviewed by the Regional Director of Maintenance to ensure that this deficient practice does not effect other policies. No new issue noted. Policies will be reviewed by the Maintenance Director or designee at least quarterly to ensure continued compliance. Results of review will be reported to the QA Team to ensure continued compliance until the problem is considered resolved or until problem is resolved.	

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	3.1-19(b)			
K 0362 SS=E Bldg. 01	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____________ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7			
	Based on observation and interview, the facility failed to ensure corridor walls in 1 of 6 smoke compartments were constructed to resist the transfer of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of Room 300. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 1:50 p.m. on 09/07/21, the annular space	K 0362	The annular space surrounding the four inch in diameter located near room 300 was fire stopped. Regional Maintenance Director made rounds the ensure that others were not effected by this deficient practice. No other issues noted. Monthly inspection for penetrations has been added to	10/04/2021

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	surrounding a four inch in diameter sprinkler pipe which penetrated the east wall of the alcove by Room 300 was not firestopped. Based on interview at the time of the observations, the Maintenance Director agreed the hole in the corridor wall would not resist the passage of smoke. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		monthly rounds via TELS. Report from TELS reporting will be reported the QA team to ensure continued compliance or until problem is resolved.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are			

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	permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors doors would resist the passage of smoke. This deficient practice could affect over 30 residents who reside on the Old Hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 1:50 p.m. on 09/07/21, a gap of greater than 3/4th inches was noted in between the face of the door and the door stop on the door frame for the corridor door to Room 106 and Room 408 and would not resist the passage of smoke. Based on interview at the time of the observations, the Maintenance Director agreed the gaps for the two corridor doors would not resist the passage of smoke. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.	K 0363	The gap in the corridor for rooms 106 and 408 has been corrected by adjustment of the hinges and installation of door seal. All other doors in the facility have been inspected by Regional Maintenance Director. One issue noted. Room 108 had a gap that did not meet requirement if this deficiency. The door has been repaired with installation of door seal kit. No other issues. Maintenance Director or designee will make monthly rounds to check doors for compliance. The rounds will be updated in TELS to ensure continued compliance. The results of audits will be reported to QA on monthly basis or until problem is considered	10/04/2021

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	3.1-19(b)		resolved.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			
	Based on observation and interview, the facility failed to ensure openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 20 residents, staff and visitors.	K 0372	The areas cited during the survey have been corrected. Annular space around the 4 fire vents in the laundry room have been patched, repaired and fire stop applied. In addition, foam was removed from red and blue water lines in the doser room near room 306. In addition, the clean utility room, 307, bathroom ceiling in room 403, 404, 408 and the beauty by the north nursing station have had UL Listed Firestop applied to correct this deficient practice. The Regional Maintenance Director has made rounds in the	10/04/2021

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 1:50 p.m. on 09/07/21, an eight inch square hole was noted in the ceiling of the Soiled Utility Room by the north nurse's station for the passage of one red water line and one blue water line. The annular space surrounding four dryer vents which penetrated the Laundry Room ceiling behind the dryers was not firestopped. In addition, foam was used to fill the hole in the ceiling for the passage of one red water line and one blue water line in the Doser Room by Room 306, the Clean Utility Room by Room 307, the bathroom ceiling in Rooms 403, 404, 408 and the Beauty Shop by the north nurse's station. Based on interview at the time of the observations, the Maintenance Director stated he did not know the UL listing of the foam used to firestop the ceiling penetrations for the water lines and agreed the aforementioned openings were not protected to maintain the fire resistance rating of the ceiling smoke barrier. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		facility to identify other areas that may be effected by the deficient practice. No new issues noted. Rounds will be conducted by the Maintenance Director or designee on a monthly basis to identify any other issues related to this deficient practice. Director or designee will reporting finding to the Administrator and Regional Director for review and verification of repair. Results of rounds will be reported to the QA Team at least monthly to ensure continued compliance or until problem is considered resolved.	
K 0914 SS=E Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155857	A. BUILDING 01 B. WING	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANQUILITY NURSING AND REHAB	3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205

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	Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)			
	Based on record review, observation and interview; the facility failed to ensure nonhospital-grade electrical receptacles in 8 of over 40 resident sleeping rooms that were replaced following annual inspection and testing were replaced with hospital-grade receptacles. NFPA 70, The National Electrical Code, 2011 Edition, at Article 517.18(B) states each patient bed location shall be provided with a minimum of four receptacles. They shall be permitted to be of the single, duplex, or quadruplex type, or any combination of the three. All receptacles, whether four or more, shall be listed "hospital grade" and so identified. It is not intended that there be a total, immediate replacement of existing non-hospital grade receptacles. It is intended, however, that non-hospital grade receptacles be replaced with hospital grade receptacles upon modification of use, renovation, or as existing receptacles need replacement. This deficient practice could affect over 5 residents.	K 0914	The electrical receptacles in room 109, 113,115,211,301, 306,308and 400 have been replaced hospital grade receptacles. Identified receptacles during the Annual tension testing will be replaced with hospital grade receptacles. The Maintenance Director will be re-educated that receptacles that fail must be replaced with hospital grade receptacles. Results of audits will be reported to the QA Team on a monthly basis to ensure continued compliance until problem is considered resolved.	10/04/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155857	A. BUILDING 01 B. WING	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANQUILITY NURSING AND REHAB	3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205

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Findings include:

Based on review of "Annual Tension Test" documentation dated 12/01/21 with the Maintenance Director during record review from 8:55 a.m. to 12:10 p.m. on 09/07/21, electrical receptacles in Room 109, 113, 115, 211, 301, 306, 308 and 400 which failed testing were listed as being replaced 12/21/20 after annual testing on 12/01/20. Based on interview at the time of the observations, the Maintenance Director stated the aforementioned electrical receptacles were listed as being replaced after annual testing on 12/21/20 with nonhospital-grade electrical receptacles. Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 1:50 p.m. on 09/07/21, the electrical receptacles in the wall mounted outlet boxes in the aforementioned 8 resident sleeping rooms were not hospital grade. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned receptacles had not been replaced with hospital grade receptacles.

This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.

3.1-19(b)