STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155226	A. BUILDING -- B. WING	06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(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. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 04/04/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/02/23 Facility Number: 000131 Provider Number: 155226 AIM Number: 100274910 At this PSR survey to the Emergency Preparedness survey, North Capitol Nursing & Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 123 certified beds. At the time of the survey, the census was 69. Quality Review completed on 06/05/23	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 04/04/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/02/23 Facility Number: 000131 Provider Number: 155226 AIM Number: 100274910	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Roland Mann	Executive Director	06/22/2023

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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	At this PSR survey, North Capitol Nursing and Rehabilitation Center was found 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. This four story facility was determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a total of 15 vent unit beds. Vent unit beds are located on the third floor in Rooms 319 through 326. The facility has a capacity of 123 and had a census of 69 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered. Quality Review completed on 06/05/23			
K 0161 SS=F Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number			

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	of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on observation and interview, the facility failed to ensure the building construction type was a permitted type as listed in Table 19.1.6.1. Table 19.1.6.1 requires a sprinklered building, four or more stories in height, to be Type II (222), Type I (332) or Type I (442). This deficient practice could affect all residents, staff and visitors. Findings include:	K 0161	What corrective actions will be accomplished for those residents found to have been affected by this deficient practice? 1. On 4/28/2023 a new FSES was completed using NFPA 101A, Guide on Alternative Approaches to Life Safety, 2001 Edition, post correction of items other than noted on K161.	06/16/2023

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	Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 12:25 p.m. to 3:15 p.m. on 04/04/23, this four story sprinklered building was constructed of unprotected steel and was determined to be Type II (000) construction. The interior load bearing wall above the suspended ceiling above the north stairwell door by Room 203, Room 302 and Room 402 was unprotected. This results in a construction type classification of Type II (000). Based on interview at the time of the observations, the Executive Director and the Director of Maintenance stated there was no change in the construction type since the most recent Life Safety Code survey and agreed interior load bearing walls consisted of unprotected steel. Based on review of "Fire Safety Evaluation System (FSES) for Health Care Occupancies" documentation dated 04/28/23 with the Executive Director and the Director of Maintenance during record review from 9:35 a.m. to 10:35 a.m. on 06/02/23, an FSES was prepared for the facility to address the building construction type deficiency. Based on interview at the time of record review, the Executive Director stated the facility had the FSES prepared to address the building construction type deficiency. Correction obviated, pending passing FSES. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)		2. How will you identify other residents that have the potential to be affected by this deficient practice? All residents and visitors have the potential to be affected by this deficient practice. 3. What measures will be put in place or what systemic changes will be made to ensure that this deficient practice does not recur? The facility completed a FSES worksheet on 4/28/2023 which resulted in all items in Worksheet 4.7.9 checked as “Yes” and all items in Worksheet 4.7.10 being identified as “Met”. The 4/28/2023 FSES demonstrates the level of fire safety is equivalent to that prescribed by NFPA 101, Life Safety Code for Healthcare Occupancies. 4. Executive Director will ensure a FSES worksheet is completed annually.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing			

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	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 Based on record review, observation and interview; the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0353	What Corrective Actions will be accomplished for those residents found to have been affected by this deficient practice? The sprinkler head in the laundry room behind the dryer was cleaned and the lint was removed on 4.10.23 The remaining sprinkler head concerns noted during the Life Safety inspection have been completed. (Proof of completion attached). How will you identify other residents that have the potential to be affected by this deficient practice and what corrective action will be taken?	06/08/2023

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	Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Wet Pipe Fire Sprinkler Systems" documentation dated 03/22/22 with the Executive Director and the Director of Maintenance during record review from 8:50 a.m. to 11:50 a.m. on 04/04/23, deficiencies were noted during the annual inspection of the facility's wet sprinkler system under Section II.A.4 of the 03/22/22 inspection report. The "Deficiency Summary" section of the 03/22/22 inspection report indicated the spare sprinkler box did not have the proper number and type of spare sprinklers, sprinkler locations on the second and third floor need to be recut in length and sprinkler heads and piping at various locations throughout the facility were corroded and need replaced. In addition, review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Wet Pipe Fire Sprinkler Systems" documentation dated 03/13/23, deficiencies were noted during the annual inspection of the facility's wet sprinkler system under Section II.A.4 of the 03/13/23 inspection report. The "Deficiency Summary" section of the 03/13/23 inspection report indicated numerous sprinkler locations throughout the facility were not "free of foreign materials including paint". The "Deficiency Summary" section of the 03/13/23 inspection report also stated, "First floor mop sink riser-(2) gauges need replace but has bad 1/4-inch 3-way globe valve needs replaced at same time". Based on interview at the time of record review, the Executive Director stated the deficiencies noted by the inspection contractor during the 03/22/22 and 03/13/23 annual inspections have not been corrected and provided "Purchase		All residents, staff, and visitors have the potential to be affected by this deficient practice. What measures will be put in place or what systemic changes will be made to ensure that this deficient practice does not recur? An audit will be completed to ensure that the sprinkler all sprinkler heads are inspected and addressed on a routine basis. The maintenance directed has been educated on inspecting, cleaning, and repairing sprinkler heads. How will the corrective actions be monitored to ensure that this deficient practice does not recur? Maintenance director or designee inspect the sprinkler heads during daily rounds and note any areas of concern. Those concerns will be immediately addressed and the results from those rounds will be submitted monthly to the Quality Assurance Committee. Inspections will occur 5 x per week for 30 days, the 1x per week x 30 days then 1 x monthly for 30 days. If no trends identified, rounds will occur per preventative maintenance schedule.	

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	Agreement" documentation dated 03/13/23 for "Sprinkler Head Replacement and Service" by the inspection contractor. The "Purchase Agreement" documentation was approved by the facility 03/15/23 but the facility is awaiting approval of the expenses by the Corporate Office. Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 12:25 p.m. to 3:15 p.m. on 04/04/23, the sprinkler location behind the dryers in the first-floor laundry was loaded with lint. This sprinkler was not included in the "Deficiency Summary" section of the 03/22/22 and 03/13/23 annual inspection reports. Based on review of the sprinkler system inspection contractor's "Sprinkler Head Replacement" letter dated 06/02/23 with the Executive Director and the Director of Maintenance during record review from 9:35 a.m. to 10:35 a.m. on 06/02/23, not all deficiencies noted on the 03/22/22 and 03/13/23 inspection reports have been corrected. The 06/02/23 letter stated "Technicians have been onsite replacing sprinkler heads quoted to be replaced. All sprinkler heads have been ordered and as soon as they are delivered, technicians will return to replace. Majority of heads have been replaced, but several were not in stock, and we are waiting on delivery. Currently, heads are taking 6-8 weeks for delivery". Based on interview at the time of record review, the Director of Maintenance stated not all deficiencies noted on the 03/22/22 and 03/13/23 inspection reports have been corrected and agreed documentation of what had been corrected at the time of the PSR was not available for review. These findings were reviewed with the Executive Director and the Director of Maintenance during			

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	the exit conference. This deficiency was cited on 04/04/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			
K 0761 SS=F Bldg. 01	Based on record review and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame.	K 0761	**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** **Facility Fire door inspection was completed on 6-14-2023 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** **The deficient practice could affect all residents, staff and visitors. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?The Maintenance Director has been trained on completion and testing of the fire doors. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The Maintenance Director/designee will maintain**	06/16/2023

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	(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire-Smoke Doors (Opening Protectives): Annual Fire/Smoke Door Inspections" dated October 2022 with the Executive Director and the Director of Maintenance during record review from 9:35 a.m. to 10:35 a.m. on 06/02/23, annual fire door inspection documentation for the facility within the most recent twelve-month period did not include fire door locations on the fourth floor. Based on interview at the time of record review,		**a log to ensure annual compliance of the fire door testing is completed. All results will be submitted to the Quality Assurance Committee.**	

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	the Executive Director and the Director of Maintenance stated the fourth floor was not currently occupied, the listing of fire doors in Direct Supply TELS computer documentation does not include the fourth floor stairwell doors, the list can only be updated by ASC Corporate staff through their Direct Supply contact and agreed annual fire door inspection documentation for the facility within the most recent twelve month period did not include fire doors on the fourth floor. The Executive Director and the Director of Maintenance contacted ASC Corporate staff during record review who had the Direct Supply TELS Logbook Documentation updated to list fourth floor fire doors to inspect in the annual fire door inspection documentation form. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. This deficiency was cited on 04/04/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			