STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 01 B. WING	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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K 0000 Bldg. 01	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). Survey Date: 04/28/17 Facility Number: 000195 Provider Number: 155298 AIM Number: 100267690 At this Life Safety Code survey, Pyramid Point Post-Acute Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(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 three story facility was determined to be of Type II (222) 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 battery operated smoke detectors in all resident sleeping rooms. The facility has a	K 0000	Plan of Correction for Pyramid Point Post Acute Rehabilitation We respectfully request Paper Compliance with submission of this plan of correction for our most recent Life Safety recertification survey on 4/28/2017. Craig Hestand, HFA Executive Director	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	capacity of 135 and had a census of 37 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered. Quality Review completed on 05/03/17 - DA			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on record review, observation and interview; the facility failed to ensure 1 of 9 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect all residents, staff and visitors if needing to exit the facility using the stairwell exit by Room 320. Findings include:	K 0211	**K 211 NFPA 101 Means of Egress-General** **Compliance Date 05/26/17** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** 1.) Area (means of egress) fire exit was immediately cleared of wheel chairs with in the affected area. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions**	05/26/2017

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	Based on review of "Disaster Planning Document" and "Fire Policy and Procedure" with the Van Driver/Maintenance Assistant during record review from 9:30 a.m. to 11:30 a.m. on 04/28/17, the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on observations with the Van Driver/Maintenance Assistant during a tour of the facility from 11:30 a.m. to 12:35 p.m. on 04/28/17, the following was noted: a. A wheeled weigh scale was unattended in the corridor outside Room 306 and outside Room 320. b. A wheeled chair was unattended in the corridor outside Room 320. c. A Hoyer lift, wheelchair and a wheeled bed frame constructed of PVC piping was unattended and stored at the end of the corridor by the stairwell exit by Room 320. Based on interview at the time of the observations, the Van Driver/Maintenance Assistant acknowledged the aforementioned means of egress was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 3.1-19(b)		**taken:** Director of Maintenance will audit exits (means of egress) with in the facility to ensure exits are free and clear of any equipment that would affect the means of egress. Director of Maintenance will mark off the means of egress area to ensure no obstructions. Staff will be in-serviced by 5/19/2016. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted of Third floor exit areas to ensure the areas are free and clear of any obstructions by the Director of Maintenance or designee 3 times per week times for 4 weeks, then monthly times 3 months to ensure compliance. Disaster Manual updated to reflect relocation of wheel equipment. Findings will be reviewed/reported at our monthly QA meeting.	

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K 0500 SS=C Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review and interview, the facility failed to ensure 5 of 5 facility service equipment had current inspection certificates to ensure the units were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the Van Driver/Maintenance Assistant from 9:30 a.m. to 11:30 a.m. on 04/28/17, current Certificate of Inspection documentation from the State of Indiana for facility service equipment was not available for review. The equipment is identified as: a. the water tube boilers identified as IN202917 and IN202918 each had a Certificate of Inspection with an	K 0500	**K-500 Building Services - Other** **Compliance Date 05/26/2017** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** **1.) Director of Maintenance followed up with insurance company for inspection certs completed 5/15/2017, Certification inspections sent to state to process certification records.** **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** **The following audits will be conducted by the Director of Maintenance or designee relating to certification of boilers is annual, but Pyramid Point will conduct audits every 6 months to ensure compliance in timely fashion.** **Inspection request for insurance company will be made prior to certification expirations. Findings will be reviewed/reported at our monthly QA meeting.**	05/26/2017

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	expiration date of 02/06/17. b. the service water heaters identified as IN252654 and IN254996 each had a Certificate of Inspection with an expiration date of 02/06/17. c. the chiller identified as IN254997 had a Certificate of Inspection with an expiration date of 02/06/17. Based on interview at the time of record review, the Van Driver/Maintenance Assistant stated each unit had a recent inspection performed by their insurance company to procure new Certificate of Inspections' documentation from the State of Indiana but inspection documentation was not available for review and acknowledged the aforementioned service equipment had expired Certificate of Inspection documentation from the State of Indiana. 3.1-19(b)			
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2.			

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	18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to:	K 0711	K 711 Evacuation and Relocation Plan Compliance Date 05/26/17 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1.) Area (means of egress) fire exit was immediately cleared of wheel chairs with in the affected area. Disaster Manual updated 5/15/17 to reflect wheeled equipment relocation plan. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Director of Maintenance will audit exits (means of egress) with in the facility to ensure exits are free and clear of any equipment that would affect the means of egress. Director of Maintenance will mark off the means of egress area to ensure no obstructions. Staff will be in-serviced by 5/19/2016. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits will be conducted of Third floor exit areas to ensure the areas are free and clear of any obstructions by the Director of Maintenance or designee 3 times per week times for 4 weeks, then monthly times 3 months to	05/26/2017

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	i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Disaster Planning Document" and "Fire Policy and Procedure" with the Van Driver/Maintenance Assistant during record review from 9:30 a.m. to 11:30 a.m. on 04/28/17, the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on observations with the Van Driver/Maintenance Assistant during a tour of the facility from 11:30 a.m. to 12:35 p.m. on 04/28/17, the following was noted: a. A wheeled weigh scale was unattended in the corridor outside Room 306 and outside Room 320. b. A wheeled chair was unattended in the corridor outside Room 320. c. A Hoyer lift, wheelchair and a wheeled bed frame constructed of PVC piping was unattended and stored in the end of the corridor by the stairwell exit by Room 320. Based on interview at the time of the		ensure compliance. 2.) Disaster Manual updated to reflect relocation of wheel equipment with staff education by 5/19/2017.. Findings will be reviewed/reported at our monthly QA meeting.	

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	observations, the Van Driver/Maintenance Assistant acknowledged the aforementioned items as being stored or left unattended within the corridors. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on record review, observation and interview; the facility failed to ensure 2	K 0920	**K-920 Electrical Equipment - Power Cords and**	05/26/2017

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	of 2 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 13 residents, staff and visitors in the vicinity of Room 303. Findings include: Based on observations with the Van Driver/Maintenance Assistant during a tour of the facility from 11:30 a.m. to 12:35 p.m. on 04/28/17, the following was noted: a. a microwave oven was plugged into a power strip in the Maintenance Office on the 1st floor. The UL listing of the power strip could not be determined. b. a refrigerator was plugged into a power strip in Room 303. The UL listing of the power strip could not be determined. Based on interview at the time of the observations, the Director of Maintenance acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned locations.		**Extens** **Compliance Date 05/26/17** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** 1.) All Power Cords were immediately removed from service. Audit conducted through out facility on 5/15/17 to ensure no other power cords in use per regulation. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** Director of Maintenance to in-service staff on power cord strip usage. Staff will be in-serviced by 05/19/2017. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted of the facility to ensure proper usage of power strips. Director of Maintenance or designee will audit 3 times per week times for 4 weeks, then monthly times 3 months to ensure compliance. Findings will be reviewed/reported at our monthly QA meeting.	

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	3.1-19(b)			