	T OF HEALTH AND HU R MEDICARE & MEDIO						M APPROVED B NO. 0938-0391
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/05/2012	
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE		
BRIARV	/OOD HEALTH AN	D REHABILITATION CENTER			APOLIS, IN 46205		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	II PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
K0000	State Licensure the Indiana Stat accordance with Survey Date: 1 Facility Numbe Provider Numb AIM Number: Surveyor: Marl Code Specialist At this Life Saf Briarwood Heat Center was four Requirements for Medicare/Media 483.70(a), Life 2000 Edition of Protection Asso Safety Code (LS Health Care Oc 16.2. This one story for be of Type II (1 sprinklered exception can fire alarm systemed to the state of the systemed systemed to the systemed to the systemed to the systemed for the systemed to the s	r: 009569 er: 155628 200139920 k Caraher, Life Safety	К0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED:

11/15/2012

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

SUMMARY S (EACH DEFICIEN REGULATORY OF	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628 C REHABILITATION CENTER TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION)	A. BUILDING B. WING STREE 3640 INDI/ ID	CONSTRUCTION 01 T ADDRESS, CITY, STATE, ZIP N CENTRAL AVE ANAPOLIS, IN 46205	сом 11/С	te survey ipleted 05/2012
DOD HEALTH AND SUMMARY S (EACH DEFICIEN REGULATORY OF	D REHABILITATION CENTER TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	STREE 3640 INDI/ ID	N CENTRAL AVE	CODE	
SUMMARY S (EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID	ANAPOLIS, IN 46205		
(EACH DEFICIEN REGULATORY OF	ICY MUST BE PRECEDED BY FULL				
REGULATORY OF			PROVIDER'S PLAN OF CO	ORRECTION	(X5)
	LSC IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	I SHOULD BE E APPROPRIATE	COMPLETI
corridor. The fa		TAG	DEFICIENCY)		DATE
	cility has smoke detectors				
	-				
at the time of the	is visit.				
All areas where	residents have customary				
access were spri	nklered, except for the				
north and south	patio exterior canopies.				
The facility has	two detached buildings				
providing facilit	y supply storage services				
which were not	sprinklered.				
-	-				
requirements as					
ionowing.					
	resident sleeping a capacity of 112 at the time of thi All areas where access were sprinorth and south The facility has providing facilit which were not a Quality Review by Code Specialist-Me The facility was with the aforeme requirements as following:		resident sleeping rooms. The facility has a capacity of 113 and had a census of 85 at the time of this visit. All areas where residents have customary access were sprinklered, except for the north and south patio exterior canopies. The facility has two detached buildings providing facility supply storage services which were not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/08/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:	resident sleeping rooms. The facility has a capacity of 113 and had a census of 85 at the time of this visit. All areas where residents have customary access were sprinklered, except for the north and south patio exterior canopies. The facility has two detached buildings providing facility supply storage services which were not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/08/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:	resident sleeping rooms. The facility has a capacity of 113 and had a census of 85 at the time of this visit. All areas where residents have customary access were sprinklered, except for the north and south patio exterior canopies. The facility has two detached buildings providing facility supply storage services which were not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/08/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:

PRINTED: 11/15/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 01 . BUILDING 155628 11/05/2012 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3640 N CENTRAL AVE BRIARWOOD HEALTH AND REHABILITATION CENTER INDIANAPOLIS, IN 46205 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG K0025 **NFPA 101** SS=E LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the K0025 The following Plan of Correction 12/05/2012 constitutes our written allegation facility failed to ensure openings through of compliance for the deficiencies 2 of 5 smoke barriers were protected to cited. Submission of the Plan of maintain the smoke resistance of each Correction is not an admission smoke barrier. LSC Section 8.3.6.1 that a deficiency exists or that one was cited correctly. This Plan requires the passage of building service of Correction is submitted to meet materials such as pipe, cable or wire to be the requirements established by protected so the space between the State and Federal law.1. Mortar penetrating item and the smoke barrier and fire chalking was applied to the openings of the 2 smoke shall be filled with a material capable of barriers in order to maintain the maintaining the smoke resistance of the smoke resistance of each smoke barrier or be protected by an barrier.1a. 58 residents could approved device designed for the specific have been affected by the openings in 2 of the smoke purpose. This deficient practice could barriers. 1b. The Maintenance affect 58 residents, staff or visitors in the Supervisor will inspect the attic vicinity of the smoke barrier wall in the monthly to ensure no breaches South Wing and 10 residents, staff and have occured.1c. Results of the monthly inspections will be visitors between the main entrance documented on the facility's reception area and the corridor leading to TEL's System. Results of the the 300 Hall. inspections will be presented to the Quality Assurance Committee monthly.1d. Corrections Findings include: completed by December 5, FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Y3W221 Facility ID: 009569 If continuation sheet Page 3 of 11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	3640	TADDRESS, CITY, STATE, ZIP CO N CENTRAL AVE NAPOLIS, IN 46205	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE PROPRIATE	(X5) COMPLETI DATE
	of Maintenance facility from 11: 11/05/12, the fol a. The smoke ba above the corrid a square access of measuring three was in the fully b. The attic smot corridor from the entrance reception openings which The openings not the annular space diameter plastic opening which re four inches long diameter opening were passed three Based on intervit observations, the acknowledged the the attic above the Wing had an opening the state of the state of the Wing had an opening the state of the state of the state of the state of the state of the Wing had an opening the state of the state of the state of the state of the state of the state of the state of the state of the wing had an opening the state of the sta	feet by two feet which open position. oke barrier wall above the e 300 Hall to the main on area had three were not firestopped. of firestopped consisted of e surrounding a one inch pipe, a rectangular neasured one inch high by and a three inch in g in which five cables ough the opening. ew at the time of the e Director of Maintenance ne smoke barrier wall in ne corridor in the South en access door in the the aforementioned		20122. The smoke barrie the attic above the corrie south wing had an open door in the wall and the mentione door had beer at the time of inspection door was closed.2a. 10 staff and visitors betwee main entrance reception the corridor leading to th hall had the potential to affected.2b. The mainter supervisor will continue monthly inspections to a door is closed and will re monthly inspection on th facilities TEL's System. has been an occurance department workman et in the attic the Maintena Supervisor will do a follo check of all open access the smoke walls to ensu are closed.2c. Results of scheduled monthly insp follow-up when the firem workman have been in t attic will be presented to Quality Assurance Committee.2d. Date of compliance December 5	dor in the aceess afore heft open . The residents, en the a area and he 300 be hance to do assure the ecord this he of fire c. being nce bw up s doors of ire they f the ection and han or any the b the	

 PRINTED:
 11/15/2012

 FORM APPROVED

 OMB NO. 0938-0391

	Γ OF HEALTH AND HU R MEDICARE & MEDIC				PRINTED: 11/15/20 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155628 155628 NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER		(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 11/05/2012	
		STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K0038 SS=E	Exit access is an readily accessibl with section 7.1. 1. Based on obs the facility failed egress through 1 accessible for re diagnosis requir measures. LSC within a required not be equipped requires the use egress side. Exc locking arrangen egress shall be p occupancies, or occupancies, wh the patients required measures for the staff can readily	ODE STANDARD ranged so that exits are e at all times in accordance 19.2.1 servation and interview, d to ensure the means of of 7 exits were readily sidents without a clinical ing specialized security 19.2.2.2.4 says doors d means of egress shall with a latch or lock that of a tool or key from the ception No. 1 states door ments without delayed permitted in health care portions of health care portions of health care the clinical needs of the specialized security eris safety, provided that unlock such doors at all cient practice could affect	K0038	The following Plan of Correctic constitutes our written allegati of compliance for the deficience cited. Submission of the Plan Correction is not an admission that a deficiency exists or that one was cited correctly. This F of Correction is submitted to ne the requirements established State and Federal law.1. The code to the lock has been place above the door on the door fract in the south dining room.1a. 5 residents, staff and visitors needing to exit the facility from the south dining room exit have the potential to be affected.1b The Maintenance Supervisor of inspect all doors to ensure coo are present.1c. Results of the monthly inspections will be documented on the facility's TEL's Surtem Boguita of the	ion cies of n t Plan neet by ced ame 88 n ve o. will des

 as a facility exit, the exit door was magnetically locked and could be opened

 FORM CMS-2567(02-99) Previous Versions Obsolete
 Event ID:

58 residents, staff and visitors needing to

Based on observation with the Director of

from 11:30 a.m. to 1:45 p.m. on 11/05/12,

Maintenance during a tour of the facility

the South Dining Room exit was marked

exit the facility from the South Dining

Room exit.

Findings include:

Event ID: Y3W221

N221 Faci

Facility ID: 009569

TEL's System. Results of the

Quality Assurance Committee

and they reactivated the electromagnetic lock on the

monthly.1d. Date of compliance December 5, 2012.2.The alarm company was called immediately

facility door by room 310.2a. 20 residents had the potential to be

affected by the electromagnetic

inspect all doors to ensure they

release and unlock during the

lock not releasing.2b. The

Maintenance Supervisor will

inspection will be presented to the

If continuation sheet Page

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:	11/15/2012
FORM AP	PROVED
OMB NO. (938-0391

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155628	a. building 01 b. wing		COMPLETED 11/05/2012	
	PROVIDER OR SUPPLIE	R D REHABILITATION CENTER	3640 N	ADDRESS, CITY, STATE, ZIP CODE I CENTRAL AVE NAPOLIS, IN 46205		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETIO	
	by entering a for was not posted. the Maintenance observation and during the exit of 11/05/12, appro- of the residents aforementioned a clinical diagno- building and acl was not posted a exit. A resident diagnosis requir measures would member to let th know the code. 3.1-19(b) 2. Based on ob- the facility faile door electroma unlocked while activated. LSC aisle, passagewa discharge, exit h in accordance w 7.2.1.6.2(e) required locking arrange electromagnetic activation of the detection system unlocked until t	ur digit code but the code Based on interview with e Supervisor at the time of with the Administrator conference at 1:50 p.m. on ximately 50 %, or more, utilizing the exit location do not have osis to be in a secure anowledged the exit code at the South Dining Room without the clinical ing specialized security I have to ask a staff nem out if they did not servation and interview, d to ensure 1 of 7 exit gnetic locks remained the fire alarm was 19.2.1 requires every ay, corridor, exit ocation, and access to be with Chapter 7. LSC aires doors with special		monthly fire drills.2c.Results the monthly inspection of the electromagnetic locks will be documented on the Facility's TEL's System. Results will b presented to the Quality Assurance Committee monthly.2d. Date compliance December 5, 2012.	e of e e s s oe	

	R MEDICARE & MEDIC						
						(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	.DING	01		COMPLETED
		155628	B. WIN			-	11/05/2012
				STREET A	DDRESS, CITY, STATE, ZIP	CODE	
NAME OF	PROVIDER OR SUPPLIEI	£		3640 N (CENTRAL AVE		
BRIARW	OOD HEALTH AND	D REHABILITATION CENTER		INDIANA	APOLIS, IN 46205		
X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID		PRESERVE	(X
REFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION)	SHOULD BE	COMPL
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DAT
	This deficient p	ractice could affect 20					
	-	nd visitors needing to exit					
	the facility by R	-					
	the facility by R	0011 510.					
	Findings include	7.					
	T mangs meruda						
	Deced on cheen	vation with the Director of					
		ring a tour of the facility					
		to 1:45 p.m. on 11/05/12,					
		etic lock on the facility					
	exit door by Roo	om 310 did not release					
	and remain unlo	cked when the fire alarm					
	was activated at	1:18 p.m. Based on					
		time of observation, the					
		ntenance acknowledged					
		etic lock on the facility					
	-	om 310 did not release					
	-	cked when the fire alarm					
		cked when the fife alarm					
	was activated.						
	2.1.10(1)						
	3.1-19(b)						

PRINTED: 11/15/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/15/2012 FORM APPROVED OMB NO. 0938-0391

	MEDICARE & MEDIC			ONGTRUCTION	OMB NO. 0938-0391
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155628	B. WING		11/05/2012
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
				I CENTRAL AVE	
BRIARW	OOD HEALTH ANI	D REHABILITATION CENTER	INDIAN	NAPOLIS, IN 46205	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR	E COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
0052	NFPA 101				
SS=C					
		em required for life safety is and maintained in			
		NFPA 70 National Electrical			
		72. The system has an			
		nance and testing program			
		lying with applicable requirements of 70 and 72. 9.6.1.4			
		vation and interview, the	K0052	The following Plan of Correct	
	-	ensure 1 of 1 fire alarm		constitutes our written allega of compliance for the deficie	
		intained in accordance		cited. Submission of the Plan	
	with the applica	ble requirements of NFPA		Correction is not an admissi	
	72, National Fir	e Alarm Code. NFPA 72,		that a deficiency exists or the	
	1-5.2.5.2 states	connections to the light		one was cited correctly. This	
	and power servi	ce shall be on a dedicated		of Correction is submitted to	
	branch circuit(s)). Circuit disconnecting		the requirements established State and Federal law.1. The	-
	means shall hav	e a red marking, shall be		alarm system breaker has be	
	accessible only	to authorized personnel,		painted red. The breaker has	
		ntified as FIRE ALARM		been identified as the FIRE	
		TROL. The location of		ALARM CIRCUIT CONTRO	
		nnecting means shall be		All residents, staff and visito had the potential to be affect	
		entified at the fire alarm		The Maintenance Director w	
		FPA 72, 1-5.2.5.3 states an		monitor monthly that the sign	
		ective device of suitable		(Fire Alarm Circuit Control) a	and
	-			red color is in place. 4.	
		capacity and capable of		TheMaintenance Supervisor	
		maximum short circuit		conduct monthly inspections information will be document	
		it may be subject shall be		on the facility's TEL's Syster	
	<u>^</u>	n ungrounded conductor.		Results of the inspections w	
		protective device shall be		submitted to the Quality	
	enclosed in a lo	cked or sealed cabinet		Assurance Committee mont	-
	located immedia	ately adjacent to the point		Date of compliance Decemb 2012.	er 5,
	of connection to	the light and power		2012.	
	conductors. This	is deficient practice could			
		nts, staff and visitors.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3W221

Facility ID: 009569

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155628		(X2) MULTIPLE CC A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 11/05/2012		
	PROVIDER OR SUPPLIEI	REHABILITATION CENTER	3640 N	ADDRESS, CITY, STATE, ZIP CO CENTRAL AVE APOLIS, IN 46205	DE	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
	Maintenance du from 11:30 a.m. the fire alarm sy identified or loc at the time of ob Maintenance act	e: vation with the Director of ring a tour of the facility to 1:45 p.m. on 11/05/12, rstem breaker could not be ated. Based on interview oservation, the Director of knowledged the fire alarm could not be identified or				

	R MEDICARE & MEDI					NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155628	A. BUILDING	01	11/05/2	
		135028	B. WING			012
NAME OF	PROVIDER OR SUPPLIE	ĒR		EET ADDRESS, CITY, STATE, ZIP CODE	3	
BRIARW	/OOD HEALTH AN	D REHABILITATION CENTER		40 N CENTRAL AVE DIANAPOLIS, IN 46205		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFI		DBE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG			DATE
K0056	NFPA 101					
SS=E						
		tomatic sprinkler system, it is rdance with NFPA 13,				
		Installation of Sprinkler				
		vide complete coverage for				
		e building. The system is				
		properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based				
	-					
		Systems. It is fully				
		supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water				
	flow and tamper switches, which are					
		lectrically connected to the building fire				
	alarm system.					
	Based on obser	Based on observation and interview, the		The following Plan of Corr	ection	12/05/20
	facility failed to provide sprinkler coverage for 2 of 3 combustible exterior			constitutes our written alle	•	ncies
				of compliance for the defic		
	Ũ	vider than 4 feet on the		cited. Submission of the P Correction is not an admis		
	-	facility. NFPA 13, 1999		that a deficiency exists or		
		n 5-13.8.1 requires		one was cited correctly. The		
	,	inklers shall be installed under		of Correction is submitted		
	-			the requirements establish		
		terior roofs or canopies		State and Federal law.1. S		
	-	et in width. This deficient		coverage has been instal		
	-	affect all residents, staff		the exterior canopy above patios outside the south di		
		eding to exit the building		room exit and outside the	-	
	from the North	and South Dining Rooms.		dining room exit.2. All resi staff and visitors needing t	dents,	
	Findings include:			the building from the north south dining room have th	e and	
	Based on obser	vations with the Director		potential to be affected. 3.		
		during a tour of the		Maintenance Supervisor w the grounds weekly and as		
		:30 a.m. to 1:45 p.m. on		all exterior canopies and e		
				roofs wider than 4 feet will		
		xterior canopy above the		sprinkler coverage.4. Res		
	patios outside t	he North Dining Room		the weekly inspection for t		

	R MEDICARE & MEDI NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER: 155628	A. BUILDING B. WING	01	COMPLETED 11/05/2012
	PROVIDER OR SUPPLIE	D REHABILITATION CENTER	3640 N	ADDRESS, CITY, STATE, ZIP COD I CENTRAL AVE NAPOLIS, IN 46205	E
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O exit and outside exit each extend nine inches) fro wood construct with automatic interview at the the Director of acknowledged North and Sout extended more building, was o was not provide sprinklers. 3.1-19(b)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) e the South Dining Room ded 69 inches (five feet om the building, was of ion and was not provided sprinklers. Based on e time of the observations,	ID PREFIX TAG	PROVIDERS PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY) presence of sprinkler cov will be documented on th facility's TELs's System. I of the inspections of the s coverage will be presente Quality Assurance Comm monthly.5. Date of compliance December 5,	LD BE ROPRIATE COMPLET erage e DATE Results sprinkler ed to the hittee Image: Complete Date
	3.1-19(ff)				

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