

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E594	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2016
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NAME OF PROVIDER OR SUPPLIER MCGIVNEY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 E 136TH ST CARMEL, IN 46033
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K 0000 Bldg. 01	<p>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).</p> <p>Survey Date: 08/29/16</p> <p>Facility Number: 000545 Provider Number: 15E594 AIM Number: 100267350</p> <p>At this Life Safety Code survey, McGivney Health Care 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 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a lower level was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard wired smoke detectors in all resident rooms. The facility has a capacity of 37 and had a census of 30 at the time of this survey.</p>	K 0000	Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under Federal and State law.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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K 0025 SS=E Bldg. 01	<p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one detached storage building which was not sprinklered.</p> <p>Quality Review completed on 08/30/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 20 residents in 1 of 2 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor on 08/29/16 between 11:00</p>	K 0025	<p>K 025 Smoke Barriers – Shall be constructed to provide a fire resistance rating of at least one half hour. Corrective action for residents affected: The penetration area have been repaired with fire rated caulking / and or repaired.</p> <p>1. Three unsealed penetrations in the ceiling of north furnace around wires and duct work were properly repaired and sealed. See Addendum A</p> <p>2. Two unsealed half of inch penetrations around a piping and unsealed two foot long by a half inch cracks were repaired, in the ceiling of storage room by</p>	09/28/2016

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	<p>a.m. and 12:00 p.m., the following areas had unsealed penetrations:</p> <p>a. In the ceiling of north furnace room there were three unsealed fourth of an inch penetrations around a wires and duct work.</p> <p>b. In the ceiling of storage room by Physical Therapy there were two unsealed half of an inch penetrations around a piping and an unsealed two foot long half inch crack.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged and provided the measurements of the penetration.</p> <p>3.1-19(b)</p>		<p>Physical Therapy. Addendum B Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this alleged deficient practice. Maintenance completed a facility – wide inspection to ensure building penetrations are properly sealed and any other building penetrations identified were documented and repaired. Measure to ensure practice does not recur: The weekly maintenance environmental form was revised and the Maintenance Supervisor will be responsible for completion, any concerns will be addressed to the Executive Director immediately. The regional Maintenance Supervisor or designee will complete an inspection of the facility monthly to ensure compliance. This corrective action will be monitored by: The Maintenance Supervisor or designee will document weekly results and report any concerns to the Administrator and the Regional Maintenance Supervisor. Repairs will be immediately addressed. Documented weekly results will be reviewed with QA monthly, until deemed unnecessary. The QA committee will advise and develop action plans to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for</p>		

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K 0038 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 exit discharge paths was readily accessible at all times. LSC Section 7.1 requires means of egress for buildings shall comply with Chapter 7. LSC Section 7.2.5.4 requires a ramp with a rise greater than 6 inches shall have handrails. LSC Section 7.2.2.4.2 Exception #3 states existing ramps shall be permitted to have a handrail on one side only. This deficient practice could affect all residents using the main entrance in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 08/29/16 at 11:30 a.m., the main entrance exit discharge handrails on the stairs were loose, wobbly, and could be pushed back and forth about six inches. Based on an interview at the time of observation, the Maintenance Supervisor acknowledged the loose handrails.</p>			K 0038	<p>on-going monitoring will be based upon compliance rates. Completion Date September 28, 2016</p> <p>K038 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. Corrective action for residents affected: The exterior handrail post base was immediately secured to the concrete decking. Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this alleged deficient practice. Maintenance completed a facility – wide inspection to ensure handrails are properly secured. Measures to ensure practice does not recur: Handrail was immediately repaired. Addendum C The Maintenance Supervisor and or Regional Director of facilities maintenance will be responsible for ensuring that hand rails are properly secured and exit access arranged so that exits are readily accessible at all times. This corrective action will be monitored by: The Maintenance Supervisor or designee will observe exit access weekly. Results will be documented and</p>		09/28/2016

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K 0147 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords in rooms 6 and 12 were not used as a substitute for fixed wiring to provide power for medical equipment. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition, 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 6 residents in rooms 6 and 12.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor</p>	K 0147	<p>reviewed by the QAcommittee monthly,until deemed unnecessary. The QAcommittee will advise and develop action plans to improve performance, whichmay include education, skills validations, performance improvement, and/ordisciplinary action. The need for on-going monitoring will be based uponcompliance rates. Completion Date September28, 2016</p> <p>K147- Electrical Wiring and Equipment shall be inaccordance with National Electrical Code</p> <p>Corrective action forresidents affected; the medical Equipment currently located in the building was inspectedto ensure proper wiring to provide power for medical equipment was connectedproperly, all portable cords and power strips were removed and medicalequipment were connected at a suitable fixed wiring port within the facilitystructure and electrical connections were placed directly into a fixed walloutlet.</p>	09/28/2016	

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	<p>on 08/29/16 between 11:07 a.m. and 11:55 a.m., an oxygen concentrator and an medical air pump was supplied with electricity by a standard extension cord power strip in room 12. Also, an oxygen concentrator and a nebulizer was supplied with electricity by a standard extension cord power strip in room six. Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p>		<p>Other residents having thepotential to be affected and corrective actions: Allresidents have the potential to be affected by this alleged deficientpractice. Maintenance completed afacility – wide inspection to ensure medical equipment is in working order andplugged directly into wall outlets. Medical equipment extension cords and powerstrips were removed.</p> <p>Measures to ensure practicedoes not recur: The weekly maintenance environmental form was revised and is theresponsibility of the Maintenance for weekly completion of unsafe observations,any concerns will be addressed to the Executive Director immediately. Regional Maintenance Supervisor or designee will conduct inspections during monthly visit for compliance. The Maintenance Supervisor conductedin–service training with all staff regarding Proper use of extension cords and</p>		

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			<p>powerstrips. Addendum D</p> <p>This corrective action will be monitored by: The Maintenance Supervisor or designee will document weekly results and report any concerns to the Administrator and Regional Maintenance Supervisor. Repairs will be immediately addressed. Documented weekly results will be presented to QA monthly until deemed unnecessary. QA committee will advise and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates.</p> <p>Completion Date September 28, 2016</p>	