

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155672	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2016
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NAME OF PROVIDER OR SUPPLIER HAMILTON GROVE	STREET ADDRESS, CITY, STATE, ZIP CODE 31869 CHICAGO TR NEW CARLISLE, IN 46552
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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: 000427 Provider Number: 155672 AIM Number: 100275150</p> <p>At this Life Safety Code survey, Hamilton Grove 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 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, in resident rooms and in areas open to the corridors. The facility has a capacity of 85 and had a census of 74 at the time of this survey.</p>	K 0000	Neither the signing nor the submission of this planshall constitute an admission of any deficiency, of any fact or conclusion setforth in the statement o deficiencies. This plan of correction is being submitted in good faith by the facilitybecause it is required by law. Thefacility reserves the right to contest the statement of deficiencies.	
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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 0038 SS=E Bldg. 01	<p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed on 09/02/16 - DA</p> <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 5 exits had a code posted. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect staff and up to 19 residents.</p> <p>Findings include:</p> <p>Based on observation with the Assistant</p>	K 0038	<p>No residents were adversely affected by this alleged deficiency.</p> <p>All five (5) coded doors were reviewed by maintenance director for compliance. Codes were reposted at all egress doors requiring those codes in order that staff/visitors and residents can readily unlock egress doors at all times. No other egress doors were effected by this alleged deficient practice. The Director of Maintenance/designee will randomly check egress doors monthly for compliance. Any deficient practice will be immediately corrected and the findings of the quality assurance checks will be documented and submitted to the monthly quality assurance committee meeting for further review or corrective action.</p> <p>The date this correction will be made by September 28, 2016.</p>	09/28/2016

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K 0062 SS=E Bldg. 01	<p>Director of Maintenance on 08/29/16 at 12:02 p.m., the corridor door near resident room 1128 was held in the locked position with a magnetic hold down device. Furthermore, the exit door was equipped with an electronic keypad entry system that allowed staff to open the locked exit doors with a combination. A code was not posted at the entrance/exit door. Based on an interview at the time of observation, the Assistant Director of Maintenance acknowledged the aforementioned condition and confirmed that there no clinical need for the doors to be locked without posting the code.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler head in the "storage room next to resident room 1119" was maintained. This deficient practice could affect staff only.</p> <p>Findings include:</p>	K 0062	<p>No residents were adversely affected by this alleged deficiency.</p> <p>For example numberone, the escutcheon was replaced in the storage room next to resident room1119. A review of the nursing units <u>did not</u> indicate other escutcheon'swere missing.</p> <p>For example numbertwo the linens were removed from the Grove clean utility room. Conspicuous</p>	09/28/2016

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	<p>Based on observation with the Assistant Director of Maintenance on 08/29/16 at 11:55 a.m., the "storage room next to resident room 1119" was missing one escutcheon. Based on interview at the time of observation, the Assistant Director of Maintenance acknowledged the missing escutcheon.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain clearance to storage for 1 of 1 Grove Clean Utility room. LSC 9.7.1.1 requires each automatic sprinkler system shall be installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1998 edition, 5-5.6 requires the clearance between the deflector and the top of the storage shall be 18 inches. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Assistant Director of Maintenance on 08/29/16 at 11:28 a.m., a couple of linens was stacked within twelve inches from the sprinkler head deflector. Based on interview at the time of observation, the Assistant Director of Maintenance acknowledged the aforementioned</p>		<p>signs were added directing staff not to place items on the top shelf of the storage rooms. These shelves are well below the 18" clearance mark required by life safety.</p> <p>The director of maintenance/designee will randomly check linen and supply closets during routine rounds. Any deficient practice will be immediately corrected and the findings of the quality assurance checks will be documented and submitted to the monthly quality assurance committee meeting for further review or corrective action.</p> <p>The date this correction will be made by September 28, 2016.</p>	

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K 0072 SS=E Bldg. 01	<p>condition and provided the measurement.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1</p> <p>Based on observation, the facility failed to maintain the means of egress free from obstructions in 1 of 2 corridors. This deficient practice could affect staff and up to 10 residents.</p> <p>Findings include:</p> <p>Based on observation with the Assistant Director of Maintenance on 08/29/16 at 11:18 a.m., the exit access corridor had a trash can in the corridor near resident room 1146. Based on interview at the time of observation, the Assistant Director of Maintenance acknowledged the aforementioned condition and confirmed that the trash can is stored there overnight.</p> <p>3.1-19(b)</p>	K 0072	<p>No residents were adversely affected by this alleged deficiency.</p> <p>The trash receptacle near room 1146 was removed immediately. A quick inspection of all the other healthcare units was undertaken, any receptacles found in the access corridor were removed. An in-service will be conducted with nursing staff regarding storage of utility receptacles and/or other objects in the access corridor. Maintenance Director/Designee will inspect the physical environment during rounds for compliance. Any deficient practice will be immediately corrected and the findings of the quality assurance checks will be documented and submitted to the monthly quality assurance committee meeting for further review or corrective action.</p>	09/28/2016

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K 0130 SS=F Bldg. 01	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 5 of 6 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p>	K 0130	<p>The date this correction will be made by September 28, 2016.</p> <p>No residents were adversely affected by this alleged deficiency. For example a, and d the "green substance" – a putty which was used inthe original construction of this building in 2000-was removed and red firerated putty was installed. For exampleb, c and e, red fire rated putty was added to ensure compliance. All other fire barriers were inspected anydeficiencies identified were immediately corrected.</p>	09/28/2016

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	<p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on an observation with the Assistant Director of Maintenance on 08/29/16 between 12:15 p.m. and 12:48 p.m., the following fire wall penetrations were discovered:</p> <p>a) a half inch penetration inside conduit in the fire barrier near resident room 1135. No documentation was available for review for the green substance used to seal up penetrations.</p> <p>b) a three quarter inch penetration inside conduit in the fire barrier near resident room 1122. A four inch by six inch piece of drywall was missing. No documentation was available for review for the green substance used to seal up penetrations. Additionally, the attic access door did not self-close when tested.</p> <p>c) a one inch by three inch penetration and a three inch by four inch penetration in the fire barrier near resident room 1112 in the attic.</p>				

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K 0147 SS=E Bldg. 01	<p>d) a half inch penetration inside conduit in the fire barrier near resident room 1100. No documentation was available for review for the green substance used to seal up penetrations.</p> <p>e) a half inch penetration in the fire barrier near resident room 1138. Based on interview at the time of each observation, the Assistant Director of Maintenance acknowledged each aforementioned condition and provided the measurements.</p> <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</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords was not used to power medical equipment. This deficient practice affects staff and up to 72 residents.</p> <p>Findings include:</p> <p>Based on observation with the Assistant Director of Maintenance on 08/29/16 at 11:05 a.m., a surge protector was powering an oxygen concentrator outside resident room 1146. Based on interview at the time of observation, the Assistant Director of Maintenance acknowledged</p>	K 0147	<p>No residents were adversely affected by this alleged deficiency. The GFCI for room 1137 and 1117 were replaced. A review of all GFCI's in the entire healthcare units were inspected. Any deficiencies identified were immediately corrected. Maintenance Director/Designee will inspect the at least 5 GFCIs monthly during PM rounds. Any deficient practice will be immediately corrected and the findings of the quality assurance checks will be documented and submitted to the monthly quality assurance committee meeting for further review or corrective action.</p>	09/28/2016

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	<p>the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 57 resident room electrical receptacles, wet location client care areas, was provided with a ground fault circuit interrupter (GFCI) protection against electric shock. LSC sections 9.1.2 requires all electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens where the receptacles are intended to serve the countertop surfaces. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and up to 23 residents.</p> <p>Findings include:</p> <p>Based on observation with the Assistant Director of Maintenance on 08/29/16 at 11:24 a.m. then again at 11:50 a.m., resident room 1137 bathroom had one GFCI receptacle within three feet of the hand sink. When the GFCI tester button</p>			

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K 0000 Bldg. 02	<p>was pressed, power was not interrupted on the GFCI receptacle. Then again, resident room 1117 bathroom had one GFCI receptacle within three feet of the hand sink. When the GFCI tester button was pressed, power was not interrupted on the GFCI receptacle. Based on interview at the time of each observation, the Assistant Director of Maintenance acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <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: 000427 Provider Number: 155672 AIM Number: 100275150</p> <p>At this Life Safety Code survey, Hamilton Grove 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</p>	K 0000	Neither the signing nor the submission of this plan shall constitute an admission of any deficiency, of any fact or conclusion set forth in the statement of deficiencies. This plan of correction is being submitted in good faith by the facility because it is required by law. The facility reserves the right to contest the statement of deficiencies.	

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	<p>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 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, in resident rooms and in areas open to the corridors. The facility has a capacity of 85 and had a census of 74 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed on 09/02/16 - DA</p>				