

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K010000	<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: 07/30/13</p> <p>Facility Number: 010758 Provider Number: 155662 AIM Number: 200229550</p> <p>Surveyors: Dennis Austill, Life Safety Code Supervisor; Robert Sutton, Life Safety Code Specialist Trainee</p> <p>At this Life Safety Code survey, Nursing Care at Hartsfield Village 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>The facility is a two story building with a one story section and a partial basement. The one story section is Type II (000) construction and the two story building is of Type II (111) construction. Because the one story and two sections of the</p>	K010000	The preparation and/or execution of the plan of correction in particular does not constitute an admission or agreement of Nursing Care at Hartsfield Village of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal laws. It is the intention of this facility that this plan or correction serves as the facility's credible allegation of compliance with all regulatory compliance.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>building are not separated by two hour rated construction, the building is considered one building of Type II (000) construction. The building is fully sprinklered with supervised smoke detectors on all levels including in corridors, in resident rooms, and in areas open to the corridor. The facility has the capacity for 112 and had a census of 97 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/09/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013	
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure two corridor room doors in 1 of 12 smoke compartments were positive latching. This deficient practice could affect 15 of 97 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 07/30/13 with the Maintenance Director during the tour from 1:30 p.m. to 4:15 p.m., the door to resident room E104 did not latch into the frame when closed and the E Hall clean linen closet door was not provided with positive latching hardware. Based on interview at the time of observation, the Maintenance Director acknowledged the door to room E104 needed adjustment to</p>	K010018	<p>1. Corrections from previous timeframes cannot be made. No residents were affected by this alleged deficient practice. The door to resident room E104 was repaired on 7-31-13. The E-Hall clean linen closet door does have positive latching hardware but was not latched properly. The door was latched properly on 7-31-13 and staff was informed that it needs to remain in the positive latching state. 2. All resident room doors will be checked for proper latching, and repairs made as needed. 3. The resident room doors will be checked monthly for proper latching during the common areas checklist inspections. The staff will be in service 8-22-13 and on-going to keep the E Hall clean linen closet door latched properly. 4. The "common areas</p>	08/29/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	latch and the E Hall clean linen closet lacked positive lathing hardware. 3.1-19(b)		checklist" concerns will be brought to the QAPI meeting for review of compliance monthly for 6 months. The staff will be inserviced on the proper latching of the clean lien closet door for the E-Hall. Maintenance Director/Assistant/Designee will check the clean linen closet door for proper latching at least daily 5 days per week for 6 months and document by signing inspection forms on the inside of the door. These results will be brought to the QAPI committee monthly for 6 months for review and/or recommendations.5.Maintenance Director responsible for compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
K010025 SS=E	<p>NFPA 101 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</p> <p>Based on observation and interview, the facility failed to ensure openings through 2 of 5 second floor smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect approximately 40 of 97 residents, staff and/or visitors using the second floor corridors if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observation on 07/30/13 with</p>	K010025	<p>1. Corrections from previous timeframes cannot be made. No residents were affected by this alleged deficient practice. a. The 2nd Floor A-Wing elevator, above the fire door will be repaired and fire stopped. b. The 2nd Floor B-Wing smoke barriers will be repaired and fire stopped. 2. a. & b. All residents on the 2nd Floor could have been affected by this alleged deficient practice, however, in this instance, no residents were affected. All the smoke barriers on the 2nd Floor will be inspected and made smoke tight 3 a. & b. All work to be performed above the ceiling and/or through a smoke barrier will be requested on a "Smoke Barrier Work Request Form" (attached #1). Staff and/or vendor will consult with the Maintenance Director and/or designated staff member about work to be performed. Part of the task will be to make sure of the integrity of the smoke barriers is</p>	08/29/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>the Maintenance Director during the tour from 1:30 p.m. to 4:15 p.m., the following was noted:</p> <p>a. The second floor A wing elevator lobby smoke barrier had a four inch hole in the drywall smoke barrier above the ceiling tile that was not firestopped.</p> <p>b. The second floor B wing smoke barrier had a four by four inch hole and a two inch pipe sleeve with penetrating wires through the drywall smoke barrier with a one inch gap which was not firestopped. The aforementioned holes in the smoke barriers were acknowledged by the Maintenance Director at the times of observation.</p> <p>3.1-19(b)</p>		<p>maintained. Upon completion, the Maintenance Director and/or Designee will sign off that the work was completed and the smoke barrier is intact.4.The generated "Smoke Barrier Work Requet Forms" will be brought to QAPI Committee meeting quarterly whenever above ceiling work is performed, on-going for review and/or recommendations.5.Director of maintenance responsible for compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013	
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>1. Based on interview and record review, the facility failed to conduct quarterly fire drills on each shift for 1 of 4 quarters. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Report of Monthly Fire Drill" with the Maintenance Director at 12:00 p.m. on 07/30/13, a fire drill was not documented for the first shift of the third quarter of 2012. Based on interview during the record review with the Maintenance Director, there was no other documentation available for review to verify this drill was conducted.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview,</p>	K010050	<p>1. Corrections from previous timeframes cannot be made. No residents were affected by this alleged deficient practice. 2. All residents, staff and visitors could have been affected by this alleged deficient practice, however, in this instance, nobody was affected. Fire drills will be conducted monthly at unexpected times and all information will be completely filled out on the fire drill form including contact with alarm company to assure signal was received. The alarm print out will be attached to each fire drill sign in sheet to complete the packet. 3. Fire drills will be conducted monthly, alternating shifts. The times per shift will be varied by approximately two hours. The midnight fire drill will consist of a silent drill and a fire alarm system check for that month. All information on the fire drill form will be completely filled out, computer print out attached, and verification noted on the form indicating the time the signal was</p>	08/29/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>the facility failed to insure fire drills included the transmission of a fire alarm signal in 2 of 7 fire drills conducted between 6:00 a.m. and 9:00 p.m. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Report of Monthly Fire Drill" with the Maintenance Director at 12:00 p.m. on 07/30/13, the documentation for the drills performed between the hours of 6:00 a.m. and 9:00 p.m. on 06/04/13 at 4:18 p.m. and 08/30/12 at 4:45 p.m. did not indicate the fire alarm system had been activated. Based on interview during the record review with the Maintenance Director, there was no other documentation available for review to verify the fire alarm system had been activated.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>received at the alarm company. Any inconsistentcies noted will be immediately addressed and corrected during the actual drills by the Maintenance Director/Designee.4.Fire drills will be copied by the Maitenance Director and submitted to the Administrator for review and signature stated all the information is completely recorded. The Maintenance Director will record the times of the fire drills, all pertinent information related to the fire drills, and bring to the QAPI Committee meeting quarterly for 1 year for review and/or recommendations.5.Maintenance Director responsible for compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K010051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure smoke detectors connected to the fire alarm system in 76 of 82 resident rooms were properly separated from an air supply. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect all 97 residents, visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 07/30/13 with</p>	K010051	1. Corrections from previous timeframes cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected by this deficient practice, however, in this instance, no residents were affected. All resident rooms were surveyed on 8-15-13. All the supply vents have built-in deflectors. The areas where the "supply vents" were closer than 3 feet to a smoke detector, the vents were adjusted to divert the airflow away from the smoke detector. The "return vents" were documented and "air deflector" were purchased, and being installed, to divert the air flow	08/29/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>the Maintenance Director during the tour from 1:30 p.m. to 4:15 p.m., all resident room electronically supervised smoke detectors with the exception of the resident rooms on the new addition were located two feet or less from an air vent. Based on interview during the times of observation, the Maintenance Director acknowledged the resident room smoke detectors were hardwired into the fire alarm system and were less than three feet from the supply or return air vent and agreed the air flow could interfere with smoke detector function.</p> <p>3.1-19(b)</p>		<p>from the smoke detectors.3. & 4The supply vents are of sturdy construction and the deverter adjustment is mechanical, and not moved easily. The return vent air diverters are mechanically connected to the vent and not easily moved. Once the air deflectors are installed, no further measures will be required.5.Maintenance Director responsible for compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
K010072 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are 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 obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to maintain the means of egress free from obstructions in 1 of 6 first floor corridors. This deficient practice could affect 3 of the 97 residents, staff or visitors.</p> <p>Findings include:</p> <p>Based on observation on 07/30/13 with the Maintenance Director during the tour from 1:30 p.m. to 4:15 p.m., the corridor outside the Occupational/Physical therapy rooms had fourteen cardboard boxes 48 inches wide and 48 inches tall lined up on one side of the corridor, reducing the width of the corridor. Based on interview at the time of observation, the Maintenance Director acknowledged these boxes contained furniture and had been there at least a week.</p> <p>3.1-19(b)</p>	K010072	<p>1. Corrections from previous timeframes cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected by this alleged deficient practice, however, in this instance, no residents were affected. The boxes were immediately removed from the hallway and placed in a storage area off the corridor. 3. The therapy room has been relocated, therefore, no therapy related activity occurs in the serve hall area. The beauty shop remains at the beginning of the service hall, therefore the service area will be kept clear of storage. Any item received that is not immediately utilized will be located in a storage area away from the service hall. 4. All management staff whose offices are located near the back service hall will monitor the hallway daily, 5 times per week to assure no items or deliveries remain in the service hall. Any large item stored/noticed in the service hall will immediately be removed and placed in a storage area. Any manager found deficient in this</p>	07/31/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
			area by storing items in non-storage areas will be re-educated per plan of correction. Results of the daily monitoring will be logged and brought to the QAPI Committee meeting quarterly for 1 year by the Maintenance Director for review and/or recommendations.5. Maintenance Director responsible for compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/30/2013	
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K010147 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure extension cords including powerstrips and non-fused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice would not directly affect residents but could affect staff.</p> <p>Findings include:</p> <p>Based on observation on 07/30/13 with the Maintenance Director during the tour from 1:30 p.m. to 4:15 p.m., an extension cord was being used as permanent wiring to a work bench with two powerstrips that were daisy chained to each other in the maintenance office. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned extension cord.</p> <p>3.1-19(b)</p>	K010147	<p>1. Corrections from previous timeframes cannot be made. No residents or staff were affected by this alleged deficient practice. The extension cord and power strips were immediately removed from the work bench following Life Safety Inspection. 2. This alleged deficient practice would have not directly affected residents however, in this instance, no residents or staff were affected. 3. Permanent conduit was installed to supply power to the work bench. 4. The deficient practice will not re-occur as the concern was resolved. 5. Maintenance Director responsible for compliance.</p>	08/14/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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