

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 04/25/2012
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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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K0000	<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: 04/25/12</p> <p>Facility Number: 010758 Provider Number: 155662 AIM Number: 200229550</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</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</p>	K0000	<p>Preparation and/or execution of the plan of correction in general, or this corrective action 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 of correction serves as the facility's credible allegation of compliance with all regulatory guidelines.</p>	
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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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	<p>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 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 in corridors, resident rooms, common areas and on all levels. The facility has the capacity for 106 and had a census of 105 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/26/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0017 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure an open use area in 1 of 8 first floor smoke compartments was separated from the corridor by smoke resistant walls, extending from the floor to the roof above, or met an Exception. LSC 19.3.6.1, Exception # 6: Spaces other than patient sleeping rooms, treatment rooms and hazardous areas may be open to the corridor and may be unlimited in area provided: (a) The space and corridors which the space opens into in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b)</p>	K0017	<p>1. Corrections for previous timeframes cannot be made. 2. This alleged deficient practice could have affected visitors, staff, and 20 or more residents in the entry lounge where residents gather for large group activities, however, no visitors, staff or residents were affected. Vendor has been contacted to submit a quote to add a smoke detector to the reception area. 3. Quote was received and approved to install smoke protection in the reception area. 4. The smoke protection installed in the reception area will be permanent and no monitoring will be required. 5. Maintenance Director responsible for compliance.</p>	05/25/2012

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	<p>Each space is protected by automatic sprinklers, or the furnishings and furniture within the area, in combination with all other combustibles within the area, are of such minimum quality and arrangement that a fully developed fire is unlikely to occur, and (c) The space does not obstruct access to required exits. This deficient practice affects visitors, staff and 20 or more residents in entry lounge where residents gather for large group activities.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/25/12 at 1:35 p.m., the reception office had a four by five foot opening into the adjacent area which could be closed with two sliding glass panels. There was a one fourth inch gap between the panels. The maintenance director confirmed at the time of observation, the office was not continuously occupied after 9:00 p.m. Additionally, the office was not protected by an electrically supervised automatic</p>				

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	<p>smoke detection system or located to permit direct supervision by the facility staff from a nurse's station or similar space when unoccupied.</p> <p>3.1-19(b)</p>			

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to provide automatic closers for doors providing access to 2 of 10 hazardous areas such as a combustibile materials storage room larger than 50 square feet. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 13 residents in service corridor and A wing.</p> <p>Findings include:</p> <p>Based on observations with the maintenance director on 04/25/12 between 3:00 p.m. and 3:45 p.m., doors separating the</p>	K0029	<p>1. Corrections for previous timeframes cannot be made. 2. This alleged deficient practice could have affected visitors, staff and 13 residents in the service corridor and the first floor A-wing, however, no visitors, staff or residents were affected. Door closures were installed for the doors seperating the 12 x 8 foot central supply storage room in the service area and the 55 square foot janitor's supply storage room on Hall 1A. 3. All storage areas were inspected and measured. All storage areas that are larger than 50 square feet without self closures had a self closure devise installed. No other areas were found to need self closure devises. 4. When the storage areas was identified and the self closing devices were installed at the affected areas, the deficient practice no longer exists. 5. Maintenace Director responsible for compliance.</p>	05/08/2012	

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	<p>twelve by eight foot central supply storage room in the service area and the 55 square foot janitor's supply storage room on 1A had did not have self closing devices. The rooms stored paper, plastic and cardboard wrapped supplies. The maintenance director said at the time of observations, he didn't know doors to these storage rooms were required to self close.</p> <p>3.1-19(b)</p>				

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K0048 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to provide 1 of 1 written fire safety plans addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2 in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect any staff in the kitchen and any residents in the vicinity of the kitchen in the event of an emergency.</p> <p>Findings include:</p>	K0048	<ol style="list-style-type: none"> 1. Corrections for previous timeframes cannot be made. 2.This deficient practice could have affected any staff in the kitchen and any residents in the vicinity of the kitchen if a fire occurred, however, in this instance, no staff or residents were affected. The facility's fire procedures were reviewed and an addendum was put in place to include the types of fire extinguishers and the special use requirements for the K Class extinguisher in the kitchen. 3.All staff will receive informal training through a posted addendum on all types of fire extinguishers available in the facility, as well as annually during fire safety in-service. In addition, the dietary staff will receive a formal in-service by the Maintenance Director/Designee on the types of extinguishers in the facility and the proper use of the K Class extinguisher in the kitchen by 5-25-12. New employees will have the fire extinguisher information presented to them during general orientation and/or departmental orientation for dietary staff. 4.The information will be part of the facility fire procedures and in-serviced annually and at all new hire orientations. 5.Director of 	05/25/2012			

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	<p>Based on a review of the facility's Fire Procedures on 04/25/12 at 1:50 p.m. with the maintenance director, the fire safety plan did not identify the types of fire extinguishers available and the special use requirements for the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The maintenance supervisor acknowledged at the time of record review, the written fire safety plan did not identify the types of fire extinguishers and mention the need to activate the overhead hood extinguishing system to suppress a fire before using the K class fire extinguisher.</p> <p>3.1-19(b)</p>		Maintenance responsible for compliance. 5.Completed 5-25-12		

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K0051 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 1 of 3 fire alarm panels in an area not continuously occupied was provided with automatic smoke detection to ensure notification of a fire at the location before it could be incapacitated by fire. LSC 9.6.2.10.1 requires smoke alarms shall be in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an</p>	K0051	<p>1. Corrections for previous timeframes cannot be made. 2. This alleged deficient practice could have affected visitors, staff, and 20 or more residents in the entry lounge where residents gather for large group activities, however, no visitors, staff or residents were affected. Vendor has been contacted to submit a quote to add a smoke detector in the entry vestibule. 3. Quote was received and approved to install smoke protection in the entry vestibule. 4. The smoke protection installed in the entry vestibule will be permanent and no monitoring will be required. 5. Maintenance Director responsible for</p>	05/25/2012			

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	<p>area continuously occupied to provide notification of a fire in that location. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/25/12 at 1:10 p.m., an adjunct fire alarm control panel (FACP) was observed in the entry vestibule, an area not continuously occupied. The area was not electrically supervised by a smoke detector. The maintenance director acknowledged at the time of observation, the panel was not provided with automatic smoke detection to ensure notification of a fire in this location before it could be incapacitated.</p> <p>3.1-19(b)</p>		compliance.	

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K0062 SS=F	<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>Based on record review and interview, the facility failed to perform weekly sprinkler system fire pump tests. NFPA 25, 5-3.2.1 requires a weekly test of electric motor driven pump assemblies shall be conducted without flowing water. This test shall be conducted by starting the pump automatically. The pump shall run a minimum of 10 minutes. This deficient practice could affect all staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of facility sprinkler system preventive maintenance records and contractor reports of Sprinkler System Inspection with the maintenance director on 04/25/12 at 2:10 p.m., evidence of weekly fire pump maintenance testing was not found. The maintenance director confirmed at the time of record review, the</p>	K0062	<p>1. Corrections for previous timeframes cannot be made. 2. This alleged deficient practice could have affected all staff, residents and visitors, however no staff, residents or visitors were affected. The Maintenance Department has begun to conduct weekly sprinkler system fire pump test. 3. Documentation will be recorded when the sprinkler system fire pump test is conducted. The documentation will be maintained in the maintenance department Life Safety book for safe keeping. 4. Documentation of sprinkler system fire pump tests will be brought to QA Committee meetings quarterly for one year for review, confirmation of completion and/or recommendations. 5. Maintenance Director responsible for compliance.</p>	05/08/2012			

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	weekly testing was not done. 3.1-19(b)			

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K0130 SS=F	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation, record review, and interview; the facility failed to ensure 6 of 6 service water heaters (SWH) and/or boilers had unexpired certificates of inspection. LSC 19.1.1.3 requires all health facilities to be maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation of rooms housing service water heaters and boilers with the maintenance director on 04/25/12 between 1:00 p.m. and 4:40 p.m. posted certificates of inspection expired on 04/25/12 for vessels #270572, #270573, #270574, #270568, #270570 and #270569 expired 01/19/12. The maintenance director said at the time of observation, he was unaware the vessel certifications had expired and confirmed no inspection was currently scheduled.</p>	K0130	<p>1. Corrections for previous timeframes cannot be made. 2. This alleged deficient practice could have affected all occupants, however, no occupants were affected. The facility's insurance company was contacted to complete the boiler inspections on April 30, 2012 and scheduled for inspection on May 10, 2012. 3. Documentation will be recorded when the boiler inspection is conducted and maintained in the maintenance office file cabinet for safekeeping. 4. The Maintenance Director will provide documentation of completion, as well as the last completion dates of the service water heaters and/or boiler to the QA Committee meeting quarterly and on-going. This documentation will be reviewed and the expiration date will be noted. Inspections will be scheduled in advance to insure that the certificates do not expire. 5. Maintenance Director responsible for compliance.</p>	05/25/2012

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