

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155208	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2012
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NAME OF PROVIDER OR SUPPLIER  HANOVER NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE RD HANOVER, IN 47243
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/11/12</p> <p>Facility Number: 000115 Provider Number: 155208 AIM Number: 100291080</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hanover Nursing 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 was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in</p>	K0000	<p>Submission of the Plan of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</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>all resident sleeping rooms. The facility has a capacity of 130 and had a census of 68 at the time of this visit.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two detached buildings; one housing the emergency generator and a metal storage building.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/25/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0025 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>1. Based on observations and interview, the facility failed to ensure 1 of 10 attic smoke barriers was constructed to provide at least a one half hour fire resistance rating. This deficient practice affects anyone using the Administration Hall and 12 residents who use the therapy gym which was located in the Administration Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 10/11/12 at 2:20 p.m., the Administration Hall attic smoke barrier wall had a two foot by six foot section of drywall missing near the center bottom of the smoke barrier wall. Furthermore, there were two, four inch by four inch penetrations which were not fire stopped around two electrical conduits. This was verified by the maintenance supervisor at the time of observation and</p>	K0025	<p>K0025 - The facility will ensure that all smoke barrier and wall penetrations will be secured with the appropriate fire retardant material to ensure at least a one half hour fire resistance rating. Then facility will ensure this requirement is met through the following corrective measures.1. All smoke barrier and wall penetrations were repaired with appropriate fire retardant material to ensure at least a one half hour fire resistance rating.2. All staff on the Administrative corridor, all residents utilizing the therapy gym and all residents residing on Wing 2 had the potential to be affected, thus the following corrective actions were taken.3. The Maintenance Director was educated on the necessity of all smoke barrier and wall penetrations being secured with appropriate fire retardant material 4. All wall, ceiling and smoke barrier partitions will be</p>	11/09/2012	

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	<p>confirmed by the corporate maintenance director at the exit conference on 10/11/12 at 2:55 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barrier and 4 of 106 room's wall 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 any residents using the Administration Hall, 12 residents who use the therapy gym, and 28 residents who reside on Wing 2.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor and corporate maintenance director on 10/11/12 during a tour of the facility from 9:50 a.m. to 2:55 p.m., the following ceiling and room smoke barriers were not fire stopped;</p> <p>a. The Wing 1 storage room had a one inch gap around the sprinkler pipe penetration on the east wall above the door, a two inch by two inch area of missing drywall on the south wall, an eight inch by six inch area of drywall missing in the closet wall, and a two inch</p>		<p>reviewed on a quarterly basis as part of the preventive maintenance program to ensure continued compliance. All construction in the facility will be monitored by the Maintenance Director or designee to ensure all penetrations are appropriately secured.5. The above corrective actions will be completed on or before 11/9/12.</p>	

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	<p>by two inch area of drywall missing on the west wall.</p> <p>b. The respiratory therapy office had a two inch circular area of drywall missing on the east wall.</p> <p>c. The Wing 1 machine room had a two inch by two inch area of drywall missing on the west wall, and a one half inch by two inch area of drywall missing in the bathroom ceiling.</p> <p>d. The Administration Hall electric room ceiling attic access panel which measured two foot by two foot, was constructed of non rated plywood.</p> <p>e. The Wing 2 housekeeping room had a three inch diameter area of missing drywall on the south wall behind the door.</p> <p>f. The Wing 2 nurses' station ceiling had a one inch circular area of drywall missing.</p> <p>g. The maintenance supervisor office ceiling had a one half inch diameter area of drywall missing.</p> <p>h. The storage room across from the maintenance supervisor office ceiling had a three inch by three inch area of drywall missing next to the smoke detector.</p> <p>i. The storage room boiler room had a four foot by two foot area of drywall separating from the ceiling with visible signs of water damage.</p> <p>j. The soiled laundry room ceiling had a two inch area around a gas pipe penetration with no fire stopping material.</p>			

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	<p>These were verified by the maintenance supervisor and corporate maintenance director at the time of observations and confirmed by the corporate maintenance director at the 2:55 p.m. exit conference on 10/11/12.</p> <p>3.1-19(b)</p>			

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K0027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 2 of 8 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 28 residents who reside on Wing 2.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor and corporate maintenance director on 10/11/12 during a tour of Wing 2 from 11:00 a.m. to 11:50 a.m., the set of smoke barrier doors by resident room 15 and the set of smoke</p>	K0027	<p>K0027 - The facility must insure that all interior smoke barrier doors must restrict the movement of smoke for at least 20 minutes. The facility will ensure that this requirement is met through the following corrective measures: 1. Repairs were completed to smoke barrier doors to ensure smoke movement is restricted for at least 20 minutes. 2. Twenty-two residents had the potential to be affected, thus the following corrective actions have been taken. 3. The two smoke barrier doors were fitted with the necessary hardware and/or adjusted in the frame to ensure that the gap measurements comply with LSC Section 8.3.4.1.4. All smoke barrier doors will be reviewed monthly as a part of the preventative maintenance program to ensure proper closing. 5. The above corrective actions will be completed on or before 11/9/12.</p>	11/09/2012			

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	<p>barrier doors by the day room each had a one inch gap between the doors in the closed position. This was verified by the maintenance supervisor and corporate maintenance director at the time of observations and confirmed by the corporate maintenance director at the 2:55 p.m. exit conference on 10/11/12.</p> <p>3.1-19(b)</p>			

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K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection 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 electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 6 of 106 rooms and 2 of 7 corridors were provided with sprinklers with the same temperature classification which operate in a timely manner and achieve effective fire control. NFPA 13, 1999 Edition, Standard for the Installation of Sprinkler Systems, 5-1.1 states the requirements for spacing, location, and position of sprinklers shall be based on the following principles: (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. NFPA 13, Table 3-2.5.1 describes Ordinary</p>	K0056	<p>K0056 - The facility must provide all rooms and corridors with sprinklers that have the same temperature classification which operate in a timely manner and achieve effective fire control. 1. All sprinkler heads were reviewed and necessary repairs/changes were contracted to a certified fire protection system contractor (SafeCare). 2. Forty-two (42) had the potential to be affected, the the following corrective actions were taken. 3. All sprinkler heads in the building will be reviewed and those "intermediate response" sprinkler heads will be changed so that all sprinkler heads have the same response specifications. In addition, all liquid-filled sprinkler heads will be replaced to conform to the metal "standard response" sprinkler head style. 4. This work will be performed by a certified fire</p>	11/09/2012			

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	<p>sprinklers as having a temperature rating of 135 to 170 degrees Fahrenheit (F) and Intermediate sprinklers as having a temperature rating of 175 to 225 degrees F. This deficient practice could affect 42 residents who reside on Wing 3.</p> <p>Findings include:</p> <p>Based on observations on 10/11/12 during a tour of the facility from 9:50 a.m. to 2:55 p.m. with the maintenance supervisor and corporate maintenance director, the following locations had Ordinary rated sprinklers and Intermediate rated sprinklers in the same rooms:</p> <p>a. The Wing 1 corridor by the Administration Hall smoke barrier had one red liquid filled Ordinary rated sidewall sprinkler (160 degrees F) and thirty metal Intermediate rated sprinkler (212 degree F).</p> <p>b. The Wing 1 morgue had had one red liquid filled Ordinary rated sidewall sprinkler (160 degree F) and two metal Intermediate rated sprinklers (212 degree F).</p>		<p>protection system contractor (SafeCare). 5. The above corrective actions will be completed on or before 11/16/12.</p>				

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	<p>c. The Wing 1 activity room had one red liquid filled Ordinary rated sidewall sprinkler (160 degree F) and one metal Intermediate rated sprinkler (212 degree F).</p> <p>d. The Wing 3 nurses' station corridor had five red liquid Ordinary rated sprinklers (160 degree F) and twelve metal Intermediate rated sprinklers (212 degree F).</p> <p>e. The Wing 3 resident room 35 had one red liquid filled Ordinary rated sprinkler (160 degree F) above bed 2 and three metal Intermediate rated sprinkler (212 degree F).</p> <p>f. The Wing 3 resident room 39 had one red liquid filled Ordinary rated sprinkler (160 degree F) and one metal Intermediate rated sprinkler (212 degree F).</p> <p>g. The Wing 3 resident room 72 had one red liquid filled Ordinary rated sprinkler (160 degree F) and one metal Intermediate rated sprinkler (212 degree F).</p> <p>h. The Wing 3 resident room 52 had one red liquid filled Ordinary rated sprinkler (160 degree F) and one metal Intermediate rated sprinkler (212 degree F).</p> <p>The sprinkler temperature rating</p>			

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	<p>was verified by the maintenance supervisor and corporate maintenance director at the time of observations and verified by observing spare sprinklers in the spare sprinkler cabinet located in the Wing 1 boiler room. The lack of sprinklers with the same temperature classification was confirmed by the corporate maintenance director at the 2:55 p.m. exit conference on 10/11/12.</p> <p>3.1-19(b)</p>				

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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>1. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler system's components was inspected quarterly for 1 of 4 calendar quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on sprinkler system record review with the administrator and maintenance supervisor on 10/11/12 at 9:50 a.m., there was no third quarter (July, August, September) of 2012 sprinkler system inspection report available for review.</p>	K0062	<p>K0062 - The facility must ensure that its fire protection system is inspected at least quarterly per LSC 4.6.12.1 and that all sprinklers must be free of foreign materials, corrosion, or paint per NFPA 25, 2-2.1.1The facility will ensure that these requirements are met through the following corrective measures:1. The appropriate fire protection system inspection has been completed; sprinkler heads have been cleaned of foreign material and/or replaced; an appropriate supply of spare sprinkler heads has been obtained.2. All residents, staff and visitors had the potential to be affected, thus the following corrective actions were taken.3. The missing quarterly sprinkler systems inspection has been completed. All inspections are maintained and documented in the Fire Safety Manual and Maintenance Department. Those sprinkler heads noted to have paint on them will be repaired/replaced. An appropriate supply of spare sprinkler heads was obtained.4. The Administrator or designee will monitor quarterly to ensure fire system inspections are occurring. All sprinkler heads will</p>	11/09/2012			

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	<p>Based on interview with the maintenance supervisor on 10/11/12 during record review, the maintenance supervisor indicated there was no written documentation or other evidence the sprinkler system had been inspected during the third quarter of 2012. This was confirmed by the corporate maintenance director at the 2:55 p.m. exit conference on 10/11/12.</p> <p>3.1-19(b)</p> <p>2. Based on observations and interview, the facility failed to ensure 3 of 106 rooms and 2 of 7 corridors were provided with sprinkler heads free of paint. LSC 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2-2.1.1 requires sprinklers to be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (upright, pendent, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 38 residents who reside on the 100 Hall.</p> <p>Findings include:</p> <p>Based on observations on 10/11/12 during a tour of the facility from 9:50 a.m. to 2:55 p.m. with the</p>		<p>be reviewed monthly as a part of the preventative maintenance plan to ensure they remain free of foreign materials, corrosion or paint. Upon use the Maintenance Director will ensure the supply of spare sprinkler heads is restocked.5. The above corrective actions will be completed on or before 11/9/12.</p>		

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	<p>maintenance supervisor and corporate maintenance supervisor, the following areas had sprinklers covered with white paint; The sprinkler in the Wing 2 day room by the piano, the sprinkler in the Wing 2 corridor across from the nurses' station, the two sprinklers in the Wing 2 corridor by resident room 25, the sprinkler in resident room 25 above bed 2, and the director of nurses office by the window. This was verified by the maintenance supervisor and corporate maintenance director at the time of observations and confirmed by the corporate maintenance director at the 2:55 p.m. exit conference on 10/11/12.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler</p>						

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	<p>wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observations on 10/11/12 during the tour of the facility from 9:50 a.m. to 2:55 p.m. with the maintenance supervisor and corporate maintenance director, red liquid filled ordinary rated sidewall and pendant sprinklers with a temperature rating of 160 degrees F were observed in Wing 1 corridor, Wing 1 rooms, and Wing 3 corridor and Wing 3 rooms. Based on observation of the spare sprinkler cabinet located in the Wing 1 boiler room on 10/11/12 at 11:10 a.m. with the maintenance supervisor and corporate maintenance director, there were no red liquid filled sidewall nor pendant sprinklers in the spare sprinkler cabinet.</p> <p>This was verified by the maintenance supervisor and corporate maintenance director at the time of observation and confirmed by the corporate maintenance director at the 2:55 p.m. exit conference on 10/11/12.</p> <p>3.1-19(b)</p>				

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K0147 SS=A	<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 1 of 34 wet location resident care areas was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 210.8, Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(B), Other Than Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens at receptacles intended to serve the counter top surfaces. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice does not affect any residents since this room is a working office for the activity director.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor and corporate maintenance director on 10/11/12 at 12:40 p.m., the activity director's office had an electric receptacle on the wall within two feet of the sink which was not provided with a ground fault circuit interrupter. Furthermore, the main electrical panel serving the area which</p>	K0147	<p>K0147 - The facility must ensure that appropriate Ground Fault Interrupter outlets are provided in wet locations. The facility will ensure that this requirement is met through the following corrective measures: 1. The electrical receptacle was replaced with a ground fault circuit interrupter in the Activity Director's Office 2. No residents had the potential to be harmed. The Activity Director had the potential to be harmed. 3. The electrical outlet in the Activity Director's office near the sink was changed out to a GFCI outlet to insure staff and/or residents are protected from the possibility of electrical shock. 4. The Maintenance Director or designee will monitor quarterly and following any construction in the facility to ensure appropriate electrical receptacles are in place. 5. The above corrective action will be completed on or before 11/9/12.</p>	11/09/2012			

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	<p>was located in the main electric room in Wing 3 was observed, and it was not provided with a ground fault circuit interrupter breaker. This was verified by the maintenance supervisor and corporate maintenance director at the time of observation and confirmed by the corporate maintenance director at the 2:55 p.m. exit conference on 10/11/12.</p> <p>3.1-19(b)</p>			