

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155307	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2012
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NAME OF PROVIDER OR SUPPLIER TOWNE CENTRE HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 7250 ARTHUR BLVD MERRILLVILLE, IN46410
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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: 01/03/12</p> <p>Facility Number: 000204 Provider Number: 155307 AIM Number: 100284910</p> <p>Surveyor: Richard D. Schade, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Towne Centre Health Care 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>	K0000	Preparation and implementation of this plan of correction does not constitute admission or agreement by Towne Centre Health Care of the truth of the facts, findings, or other statements as alleged by the preparer of the survey/inspection dated 1-3-12. Towne Centre Health Care specifically reserves the rights to move to strike or exclude this document as evidence in any civil, administrative, and criminal action not related directly to the licensing and/or certification of this facility or provider.	

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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K0048 SS=F	<p>This 1987, two story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on the first floor only, including the corridors and spaces open to the corridors. The facility has a capacity of 120 and had a census of 85 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/06/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>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 a written fire plan which includes the procedures for the use of all types of fire extinguishers in the facility for the protection 120 of</p>	K0048	<p>K048</p> <p>Note: The date of 1-12-10 referred to by the surveyor as the date the "Emergency Potable Water Agreement" dated 1-12-10 which has been placed within the viewable flap of all of the Disaster Manuals for ready accessibility,</p>	02/02/2012

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	<p>120 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan which shall provide policy and procedures 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 all occupants, visitors and staff in the facility in the event of an emergency when the written fire plan should be immediately available.</p> <p>Findings include:</p> <p>Based on record review with the maintenance supervisor and facility administrator on 01/03/12 at 1:55</p>		<p>had been reviewed. The Emergency Procedure Manual had been reviewed and clearly labeled as "updated 7-24-2011" on the first page of the manual. Also, the portable extinguishers in the kitchen that were described in the 2567 as "K" are actually "BC".</p> <ol style="list-style-type: none"> 1) The Procedures for the use of all types of fire extinguishers in the Health Care facility have been updated. 2) All residents have the potential to be affected. The fire plan will be reviewed, updated and kitchen staff will be in-serviced on proper use of fire extinguishers in the facility. 3) The procedure for fire extinguisher use and the relationship with the Class K hood suppression system will be reviewed, updated and the Kitchen staff will be in-serviced on any updated procedures related to the hood suppression system and the fire extinguishers by 2-2-12. 4) A monthly Fire Drill will be conducted in the main kitchen by the Dietary Manager/designee to assure Kitchen Staff have a clear understanding and quick response to what actions to take in the case of engagement of Hood Suppression system and fire extinguishers in the main kitchen. The Dietary Manager will provide a summary of these drills to the monthly QA committee. A compliance threshold of 100% 		

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	<p>p.m., the written fire plan was found within the Emergency Procedure manual and the administrator stated it was recently reviewed. Documentation within the manual showed the last review was 01/12/10. This Plan was the corporate policy which requires information specific to the facility. The policy failed to identify the types of extinguishers in the facility, the fires they are to be used for and the procedures on how to use each type of extinguisher. The manual did not address the relationship of the use of the Class K extinguisher with the hood suppression system. At the time of record review, the maintenance supervisor stated he was unaware of the requirement for the fire plan extinguisher policy and procedure.</p> <p>3.1-19(b)</p>		<p>has been established by the QA team to ensure a measurable system is in place not only to ensure ongoing compliance, but also to effectively identify areas of non-compliance on an ongoing basis. If compliance thresholds are not achieved within the first 90 days then the monitoring period will be extended to a level found appropriate by the QA team.</p> <p>5) By 2-2-12.</p>		

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K0062 SS=F	<p>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 observation, record review and interview; the facility failed to ensure 2 of 2 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 01/03/12 at 1:25 p.m. with the maintenance supervisor and facility</p>	K0062	<p>K062</p> <p>1) The fire hydrant inspection has been scheduled and will occur before 2-2-12.</p> <p>2) All residents have the potential to be affected. The hydrants will be inspected annually as required.</p> <p>3) Maintenance Supervisor will be educated on the Life Safety Code requirements for Long Term Care by 2-2-12. The Inspections for private hydrants will be placed on the annual inspection log.</p> <p>4) Every month, the Executive Director will audit annual maintenance logs for proper timely completion of inspections. Results of audits will be provided to the monthly QA. A compliance threshold of 100% has been established by the QA team to ensure a measurable system is in place not only to ensure ongoing compliance, but also to effectively identify areas of non-compliance on an ongoing basis. If compliance thresholds are not achieved within the first 90 days then the monitoring period will be extended to a level found appropriate by the QA team.</p> <p>5) By 2-2-12</p>	02/02/2012	

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K0064 SS=E	<p>administrator, the facility lacked documentation to show the two private fire hydrants on the facility's property had an annual inspection in the past year. Documentation showed McDaniel last inspected the hydrants on 09/21/09. The maintenance supervisor stated at the time of record review, he was not aware of the requirement.</p> <p>3.1-19(b)</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to inspect 3 of 3 portable fire extinguishers on the second floor each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires monthly fire extinguisher inspections with at least the date of inspection and the initials of the person performing the inspection being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick</p>	K0064	<p>K064</p> <p>1) All fire extinguishers in Health Care have been inspected and documentation has been provided.</p> <p>2) All residents have the potential to be affected. All fire extinguishers in Health Care have been properly inspected.</p> <p>3) The Maintenance Supervisor has been re-educated by 2-2-12 on the Life Safety Code inspections that need to be completed on a monthly basis. The Executive Director/designee will audit a random sampling of 2 fire extinguishers per month on each floor to assure proper documentation is present and</p>	02/02/2012

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	<p>check" a fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with, and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect all residents, staff and visitors on the facility's second floor.</p> <p>Findings include:</p> <p>Based on observation on 01/03/12 between 2:15 p.m. and 3:00 p.m. with the facility administrator and maintenance supervisor, the fire extinguishers had received the annual inspection in November 2011. The monthly inspection tags attached to the portable fire extinguishers on the second floor lacked documentation of a monthly inspection for the month of December. The maintenance supervisor stated at the time of the</p>		<p>timely and will document results on the monthly logs. The Executive Director will audit the monthly inspection logs to be completed by the Maintenance Supervisor prior to the end of the month to assure proper completion has been accomplished timely. 4) The Executive Director will summarize the results of the audits and present to the monthly QA committee. A compliance threshold of 100% has been established by the QA team to ensure a measurable system is in place not only to ensure ongoing compliance, but also to effectively identify areas of non-compliance on an ongoing basis. If compliance thresholds are not achieved within the first 90 days, then the monitoring period will be extended to a level found appropriate by the QA team. 5) By 2-2-12.</p>		

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K0144 SS=F	<p>observations, he thought the inspections were current, but the extinguishers were overlooked.</p> <p>3.1-19(b)</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure emergency task lighting in and around 1 of 1 generator sets was in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.3 requires an annual functional test to be conducted on emergency battery lighting systems for not less than 90 minutes. NFPA 110, Section 5-3.1 requires that EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, staff and visitors in the facility.</p>	K0144	<p>K144</p> <p>1) The Battery powered emergency lighting at the generator site has been tested for 90 minutes.</p> <p>2) All residents have the potential to be affected by the deficient practice. The Battery powered emergency lights has been properly tested and has met the annual inspection requirement.</p> <p>3) The Maintenance Supervisor will be re-educated by 2-2-12 on the routine inspection requirements for Life Safety Codes in Long Term Care. The inspection for emergency lighting at the generator site will be placed on an annual inspection log.</p> <p>4) Every month, the Executive Director will audit the annual maintenance logs for proper timely completion of inspections. Results of the audits will be provided to the monthly QA. A compliance threshold of 100% has been established by the QA</p>	02/02/2012

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	<p>Findings include:</p> <p>Based on record review with the maintenance supervisor and facility administrator on 01/03/12 at 1:40 p.m., the maintenance supervisor acknowledged he had no record of the battery powered lighting at the generator being tested for 90 minutes annually. The maintenance supervisor stated at the time of record review, he thought the annual 90 minute test had been completed but had no documentation.</p> <p>3.1-19(b)</p>		<p>team to ensure a measurable system is in place not only to ensure ongoing compliance, but also to effectively identify areas of non-compliance on an ongoing basis. If compliance thresholds are not achieved within the first 90 days then the monitoring period will be extended to a level found appropriate by the QA team.</p> <p>5) By 2-2-12.</p>		