

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155381	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/20/2015
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NAME OF PROVIDER OR SUPPLIER HARBOUR MANOR HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1667 SHERIDAN RD NOBLESVILLE, IN 46060
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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: 01/20/15</p> <p>Facility Number: 000551 Provider Number: 155381 AIM Number: 100267400</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Harbour Manor Health & Living Community 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) and 410 IAC 16.2.</p> <p>This facility was surveyed as three separate buildings due to the construction dates of three sections of the building. Building 0102 constructed prior to March 1, 2003 was determined to be a one story facility of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in</p>	K010000		
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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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K010029 SS=E	<p>the corridors and in all areas open to the corridor. Building 0102 has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 135 and had a census of 110 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached garage providing facility storage services which was not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 01/26/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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>						

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	<p>Based on observation and interview, the facility failed to ensure 1 of 2 doors leading to hazardous areas such as the kitchen would self close. This deficiency could affect 7 residents observed in the Main dining room which is adjacent to the kitchen as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/20/15 at 1:35 p.m. with the Maintenance Supervisor, the kitchen door which separates the kitchen from the adjacent dining room which opens up to Center hall was not equipped with a self closing device on the door. Based on interview on 01/20/15 concurrent with the observation with the Maintenance Supervisor it was acknowledged the aforementioned kitchen door did not self close because of an absence of a self closing device on the door.</p> <p>3.1-19(b)</p>	K010029	<p>TAG # K 029</p> <p>1. The corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The facility failed to ensure 1 of 2 doors leading to hazardous areas such as the kitchen would self-close. There was no self-closing device on the door which separates the kitchen from the adjacent dining room which opens up to the center hall.</p> <p>The corrective action taken will be to install a self-closing device that meets K 029 NFPA LIFE SAFETY CODE STANDARD</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice. What corrective action(s) will be taken?</p> <p>All residents, visitors and staff have the potential to be affected by the alleged deficient practice.</p> <p>III. The facility will put into place the following systemic changes to ensure that the deficient practice does not recur.</p> <p>Maintenance will install a self-closing device to prevent exposure to any hazardous areas</p>	02/19/2015

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K010038 SS=E	<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 Based on observation and interview, the facility failed to ensure exit access discharge was arranged so 1 of 12 exits were readily accessible at all times. LSC Section 7.1 at Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public</p>	K010038	<p>IV. The facility will monitor the corrective action by implementing the following measures.</p> <p>The Maintenance Director will conduct staff training to ensure proper safety procedures are followed. No propping of door open exposing residents, visitors and staff to hazardous areas.</p> <p>Proper procedure will be checked 3 x weekly x 4 weeks, weekly x 4 weeks, then monthly during building inspections by maintenance.</p> <p>V. Plan of action completion date.</p> <p>Plan of Correction date is February 19, 2015</p> <p>TAG # K 038</p> <p>1. The corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The facility failed to ensure clear path for exit discharge from south exit directly from the dining area. The exit discharge is not paved completely and ends into a grass</p>	02/19/2015

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	<p>way. Exterior walking surfaces within the exit discharge are not required to be paved and may be provided by grass or similar surfaces. However, where discharging exits into yards, across lawns, or on similar surfaces, in addition to providing the required width to allow all occupants safe access to a public way, such access also needs to meet the requirements with respect to maintaining the means of egress free of obstructions that would prevent its use, such as snow and the need for its removal in some climates or soft ground during heavy periods of rain. This deficient practice could affect 7 residents in the main dining room as well as visitors and staff if the facility were required to evacuate.</p> <p>Findings include:</p> <p>Based on observation on 01/20/15 at 1:15 p.m. with the Maintenance Supervisor, the south exit leading out of the main dining room discharged onto a grass surface which leads to a public way.</p> <p>Based on interview on 01/20/15 at 1:21 p.m. with the Maintenance Supervisor it was acknowledged the south exit for the Main dining room discharged onto a grassy surface. Further interview with the Maintenance Supervisor revealed the grassy surface can not be maintained during snow or heavy periods of rain.</p>		<p>area.</p> <p>The corrective action taken will be to install a concrete side walk immediately adjacent to the ending of the paved lane allowing residents, visitors, and staff safe egress to a public way. The new side walk will meet the K 038 NFPA LIFE SAFETY CODE STANDARD</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice. What corrective action(s) will be taken?</p> <p>All residents, visitors and staff have the potential to be affected by the alleged deficient practice.</p> <p>III. The facility will put into place the following systemic changes to ensure that the deficient practice does not recur.</p> <p>Maintenance/Vender will install a new concrete egress allowing safe access to a public way.</p> <p>IV. The facility will monitor the corrective action by implementing the following measures.</p> <p>Maintenance will continue to practice procedure ensuring snow removal when required and constant clear obstruction free egress from exit discharge at all times.</p>	

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K010045 SS=E	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to ensure the lighting in 1 of 12 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect any residents as well as visitors and staff, if the facility were required to evacuate out the south dining room exit in an emergency and the single bulb outside light fixture failed.</p> <p>Findings include:</p> <p>Based on observation on 01/20/15 at 1:00 p.m. with the Maintenance Supervisor the south dining room exit had only one single bulb fixture on generator backup to provide illumination for the exit discharge to a public way. Based on interview with the Maintenance Supervisor concurrent with the</p>	K010045	<p>V. Plan of action completion date.</p> <p>Plan of Correction date is February 19, 2015</p> <p>TAG # K 045</p> <p>1. The corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Facility failed to ensure proper illumination of means of egress at south exit from dining room. Single bulb fixture did not meet K 045 NFPA LIFE SAFETY CODE STANDARD</p> <p>The corrective action taken will be to install a new dual bulb fixture that is compliant with the K 045 NFPA LIFE SAFETY CODE STANDARD</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice. What corrective action(s) will be taken?</p> <p>All residents, visitors and staff have</p>	02/19/2015
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K010066 SS=E	<p>observation it was acknowledged south dining room exit had only a single bulb light fixture available to illuminate the exit discharge.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p>		<p>the potential to be affected by the alleged deficient practice.</p> <p>III. The facility will put into place the following systemic changes to ensure that the deficient practice does not recur.</p> <p>Maintenance will install an appropriate dual bulb fixture allowing proper illumination for means of egress</p> <p>IV. The facility will monitor the corrective action by implementing the following measures.</p> <p>Maintenance will continue to perform required regularly scheduled facility inspections to ensure proper illumination at all egress locations at all times</p> <p>V. Plan of action completion date.</p> <p>Plan of Correction date is February 19, 2015</p>		

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	<p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, record review and interview, the facility failed to ensure 1 of 1 smoking policies was adhered to which does not allow smoking on the premises of the facility. This deficient practice could affect 24 residents on west hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/20/15 at 2:15 p.m. with the Maintenance Supervisor, forty six cigarette butts were observed deposited on the ground adjacent to the generator outside west hall, south exit. Based on review of the smoking policy on 01/20/15 at 3:32 p.m. with the Maintenance Supervisor, the smoking policy did not allow smoking on facility grounds. Based on interview on concurrent with the observation with the Maintenance Supervisor it was acknowledged the facility's employees</p>	K010066	<p>TAG # K 066</p> <p>I. The corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The facility failed to ensure that the no smoking policy is being adhered to which does not permit smoking on the property.</p> <p>The corrective action taken will be to install no smoking signs at all entrance locations. Additionally acceptable containers will be located at the employee entrance</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice. What corrective action(s) will be taken?</p> <p>All residents, visitors and staff have the potential to be affected by the alleged deficient practice.</p>	02/19/2015

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K020000	<p>were throwing their cigarette butts on the ground instead of into a metal container.</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: 01/20/15</p> <p>Facility Number: 000551 Provider Number: 155381</p>	K020000	<p>III. The facility will put into place the following systemic changes to ensure that the deficient practice does not recur.</p> <p>Maintenance will install proper signage and acceptable containers that meet the K 066 NFPA LIFE SAFETY CODE STANDARD</p> <p>IV. The facility will monitor the corrective action by implementing the following measures.</p> <p>The Maintenance Director will conduct audits 3 x weekly x 4 weeks, weekly x 4 weeks, then monthly during building inspections by maintenance.</p> <p>V. Plan of action completion date.</p> <p>Plan of Correction date is February 19, 2015</p>	

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	<p>AIM Number: 100267400</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Harbour Manor Health & Living Community was found 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), and 410 IAC 16.2. Building 0202 and Building 0302, the newly constructed Rehab Building, were surveyed using Chapter 18, New Health Care Occupancies.</p> <p>This facility was surveyed as three separate buildings due to the construction dates of three sections of the building. Building 0202 and Building 0302 constructed in 2013, are each one story determined to be of Type V (111) construction and fully sprinklered. Building 0202 consists of the Activities Room and Building 0302 consists of the Rehab Building. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. Building 0302 has smoke detectors hard wired to the fire alarm system installed in all 40 resident</p>						

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K020052 SS=E	<p>sleeping rooms. The facility has a capacity of 135 and had a census of 110 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached garage providing facility storage services which was not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 01/26/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 12 manual fire alarm boxes were unobstructed and readily accessible. NFPA 72, National Fire Alarm Code, 2-8.2.1 states manual fire alarm boxes shall be distributed throughout the protected area so they are unobstructed, readily accessible, and located in the path of exit from the area.</p>	K020052	<p>TAG # K 052</p> <p>1. The corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The facility failed to ensure 1 of 12 fire alarm boxes were unobstructed and readily accessible.</p>	02/19/2015

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	<p>This deficient practice could affect 16 residents on Administrative hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/20/15 at 12:15 p.m. with the Maintenance Supervisor the manual fire alarm box was on the other side of the front exit doors with magnetic locks which were only accessible by the use of a keypad override code which would disengage the magnetically locked doors thus delaying alarm notification to facility occupants. Based on interview on 01/20/15 concurrent with the observation with the Maintenance Supervisor it was acknowledged the manual fire alarm box was not accessible once inside the facility unless the keypad override code was used to first disengage the magnetically locked doors.</p> <p>3.1-19(b)</p>		<p>The corrective action taken will be to relocate fire pull station from obstructed area and allow full access which meets the K 052 NFPA LIFE SAFETY CODE STANDARD</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice. What corrective action(s) will be taken?</p> <p>All residents, visitors and staff have the potential to be affected by the alleged deficient practice.</p> <p>III. The facility will put into place the following systemic changes to ensure that the deficient practice does not recur.</p> <p>Certified Vender will relocate fire box to the appropriate location in the front of the building allowing proper access.</p> <p>IV. The facility will monitor the corrective action by implementing the following measures.</p> <p>Continued building and facility inspections.</p> <p>V. Plan of action completion date.</p> <p>Plan of Correction date is February 19, 2015</p>	