

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 03/16/2015
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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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K 000 Bldg. 01	<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: 03/16/15</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 sprinkled. 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>	K 000	<p>Submission of this 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. This 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. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</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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K 018 SS=E Bldg. 01	<p>all resident sleeping rooms. The facility has a capacity of 125 and had a census of 55 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has a detached wooden storage garage and a detached wooden building housing the emergency generator which was not sprinkled.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/19/15.</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 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</p>			

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	<p>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 3 of 98 corridor doors in the healthcare portion of the building were constructed to resist the passage of smoke or provided with a means suitable for keeping the door closed. This deficient practice could affect 2 residents who reside in rooms 18, staff who use the employee break room and any number of residents, staff and visitors who would use the public restroom in the Administration Hall.</p> <p>Findings include:</p> <p>Based on observations on 03/16/15 during a tour of the facility from 9:20 a.m. to 12:55 p.m. with the maintenance supervisor, the Administration Hall public restroom lacked a door knob and latching device. Furthermore, the Service Hall employee break room and resident room 18 doors each had a one inch gap along the latching sides of the doors with the doors in the closed position. This was verified by the maintenance supervisor at the time of observations and acknowledged by administrator at the exit conference on 03/16/15 at 1:20 p.m.</p>	K 018	<p>1. The Administration Hall public restroom door has been removed and replaced with a new door that closes and latches properly. Additionally, the doors to the Service Hall employee break room and Resident Room #18 had weather stripping added to the door frame to remedy the one inch gap along the latching sides of the doors with the doors in the closed position. 2. In an effort to identify any other doors within the facility that either did not close and latch properly or exhibited a gap with the door in the closed position, all doors were inspected by the Maintenance Director with no additional concerns noted.3. In an effort to ensure ongoing compliance, the Maintenance Director will receive education regarding ensuring all doors within the facility are constructed to resist the passage of smoke and are equipped with a means suitable for keeping the door closed, (See Attachment A).4. As a means of quality assurance, the Maintenance Director/designee will monitor all doors within the facility to ensure they are constructed to prevent the passage of smoke and are equipped with a means suitable for keeping the door closed as part of the facility's preventative maintenance program. Should</p>	04/15/2015	

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K 147 SS=B Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 4 soiled linen rooms was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas that are subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affects</p>	K 147	<p>concerns and/or non-compliance be noted, corrective action shall be taken. The monitoring and any corrective action taken will be reviewed at least quarterly by the facility QA Committee with the plan of action adjusted accordingly, as warranted. 5. The above corrective action will be completed on or before April 15, 2015.</p> <p>1. The electric outlet in the Wing 3 Soiled Linen Room was updated to include ground-fault circuit interrupter (GFCI) protection.2. In an effort to identify any other wet areas without GFCI protection within the facility, the Maintenance Director conducted an audit of all electrical outlets, with no concerns noted.3. In an effort to ensure ongoing compliance the Maintenance Director will receive education regarding ensuring electrical outlets in areas with moisture include GFCI protection, (See Attachment A).4. As a means of quality assurance, the Maintenance Director/designee will monitor the installation of any new electrical outlets within the facility and ensure that those installed in wet areas include GFCI protection as part of the facility's preventative</p>	04/15/2015	

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	<p>Wing 3 staff that uses the soiled linen room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 03/16/15 at 11:50 a.m., the Wing 3 soiled linen room had an electric outlet two feet from the soiled linen wash sink with no ground fault circuit interrupter on the electric outlet. Based on observation of the main electrical breaker panel with the maintenance supervisor at the time of observation, the circuit breaker for the electric outlet in the Wing 3 soiled linen room was not provided with GFCI protection. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 03/16/15 at 1:20 p.m.</p> <p>3.1-19(b)</p>		<p>maintenance program. Should concerns and/or non-compliance be noted, corrective action shall be taken. The monitoring and any corrective action taken will be reviewed at least quarterly by the facility QA Committee with the plan of action adjusted accordingly, as warranted. 5. The above corrective action will be completed on or before April 15, 2015.</p>		