

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155672	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/14/2015
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NAME OF PROVIDER OR SUPPLIER HAMILTON GROVE	STREET ADDRESS, CITY, STATE, ZIP CODE 31869 CHICAGO TR NEW CARLISLE, IN 46552
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K 0000 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: 09/14/15</p> <p>Facility Number: 000427 Provider Number: 155672 AIM Number: 100275150</p> <p>At this Life Safety Code survey, Hamilton Grove 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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in resident rooms and in areas open to the corridors. The facility has a capacity of 85 and had a census of 77 at the time of this survey.</p>	K 0000	F 000 Neither the signing nor the submission of this plan shall constitute an admission of any deficiency, of any fact or conclusion set forth in the statement of deficiencies. This plan of correction is being submitted in good faith by the facility because it is required by law. The facility reserves the right to contest the statement of deficiencies.	

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 0025 SS=E Bldg. 01	<p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed on 09/16/15 - DA</p> <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>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 7 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke</p>	K 0025	<p>K 025 No residents were adversely affected by this alleged deficiency. The first two inch by four inch unsealed penetration area above the ceiling tile was repaired with approved fire proof material (dry wall compound) on September 14, 2015. The second penetration gap surrounding the sprinkler pipe by resident room 1156 is scheduled to be corrected on Monday, September 28, 2015 by Hamilton's contracted fire protection service provider. Effective October 14, 2015 a quality-assurance program will be implemented under the supervision of the director of Maintenance to monitor any new</p>	10/14/2015

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K 0044 SS=E Bldg. 01	<p>resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect staff and twenty residents.</p> <p>Findings include:</p> <p>Based on observations with the Assistant Manager on 09/14/15 at 12:51 p.m. then again at 1:14 p.m., the corridor wall by resident room 1136 had a two inch by 4 inch unsealed penetration above the ceiling tile. Then again in the attic, the smoke barrier wall had a two inch unsealed penetration gap around the sprinkler pipe by resident room 1156. Based on interview at the time of each observation, the Assistant Manager acknowledged each of the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with</p>	K 0044	<p>unsealed wall penetrations caused by new or existing repairs. The director of Maintenance or designated quality assurance representative will perform the following systemic changes: randomly checking, monthly, at least 2 fire barrier walls for unsealed penetrations. Any deficiencies will be corrected immediately and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. This will be done monthly for ninety (90) days then quarterly thereafter.</p> <p>K 044 No residents were adversely affected by this alleged deficiency. The door latch was repaired on 9-24-2015. Effective October 14, 2015 a quality-assurance program will</p>	10/14/2015	

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K 0062 SS=C Bldg. 01	<p>7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect at least 20 residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Assistant Manager on 09/14/15 at 1:29 p.m., the fire barrier doors near resident room 1100 were tested and one of the two doors failed to latch. Based on interview at the time of observation, the Assistant Manager acknowledged both sets of doors were fire doors and acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <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 ensure 1 of 1</p>	K 0062	<p>be implemented under the supervision of the director of Maintenance to monitor all healthcare door latches to ensure proper closure. The director of Maintenance or designated quality assurance representative will perform the following systemic changes: As part of Hamilton Grove's ongoing preventivemaintenance program all automatic fire door latches will be checked at least weekly for 30 days then monthly thereafter. Any deficiencies will be corrected immediately, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action.</p> <p>K 062 No residents were adversely affected by this alleged deficiency. The five year</p>	10/14/2015

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	<p>automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on record review with the Assistant Manager on 09/14/15 at 10:31 a.m., the last internal sprinkler inspection titled "Sprinkler Inspection Report" was performed on 03/2010 by Koorsen Fire and Security. Based on interview at the time of record review, the Assistant Manager acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>inspection required by NFPA 25 10-2.2 is scheduled to be inspected on September 28, 2015 by Hamilton Grove's contracted fire protection vendor. Effective October 14, 2015 a quality-assurance program will be implemented under the supervision of the director of Maintenance to monitor any new unsealed wall penetrations cause by any new or existing repairs. The director of Maintenance or designated quality assurance representative will perform the following systemic changes: As part of Hamilton Grove's ongoing preventive maintenance program all scheduled fire inspections required by NFPA 25 section 10-2.2 will be reviewed annually to ensure compliance. Any deficiencies will be corrected immediately, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further reviewer corrective action.</p>	

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K 0130 SS=E Bldg. 01	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 1 of 3 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance</p>	K 0130	<p>K 130 No residents were adversely affected by this alleged deficiency.</p> <p>The Fire penetration wall noted by the inspector in the attic near resident room 1156 is scheduled to be corrected on Monday, September 28, 2015 by Hamilton's contracted fire protection service provider.</p> <p>Effective October 14, 2015 a quality-assurance program will be implemented under the supervision of the director of Maintenance to monitor any new wall penetration breaches caused by new repairs.</p> <p>The director of Maintenance or designated quality assurance representative will perform the following systemic changes: randomly checking, monthly, at least 2 fire barrier walls for unsealed penetrations. Any deficiencies will be corrected immediately, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. This will be done monthly for ninety (90) days then quarterly thereafter.</p>	10/14/2015	

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K 0147 SS=D Bldg. 01	<p>of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect residents in 2 of 7 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Assistant Manager on 09/14/15 at 1:13 p.m., the attic fire barrier wall near resident room 1156 had an unsealed penetration measuring two inches around a sprinkler pipe. Based on interview at the time of observation, the Assistant Manager acknowledged the aforementioned condition.</p> <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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for</p>	K 0147	<p>K147 No residents were adversely affected by this alleged deficiency. On 9.14.2015 surge protector was removed from the staff's office. The refrigerator was plugged directly into the wall receptacle. Effective October 14, 2015 a quality-assurance program will be implemented under the supervision of the director of</p>	10/14/2015

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	<p>fixed wiring of a structure. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observation with Assistant Manager on 09/14/15 at 12:00 p.m., a surge protector was powering a refrigerator in the Director of Nursing office. Based on interview at the time of observation, the Assistant Manager acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>Maintenance to monitor all healthcare offices to ensure no surge(strip) protectors are being used.</p> <p>The director of Maintenance or designated quality assurance representative will perform the following systemic changes: randomly checking weekly for the presence of surge (strip) protectors in all healthcare offices. Any discovered in use will be immediately removed, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. This will be done weekly for 30 days then quarterly thereafter.</p>	