

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 05/21/2014 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|--|----------------------|
| 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: 05/21/14</p> <p>Facility Number: 000231 Provider Number: 155338 AIM Number: 100267900</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Manorcare Health Services - Prestwick 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. Building 0101, the original building was surveyed using Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building 0101, built prior to March 1, 2003, was determined to be of</p> | K010000 | The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated. | |

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.

| | | | | | | | |
|---|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/21/2014 | |
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| K010046 SS=E | <p>Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in 64 of 79 resident sleeping rooms and has smoke detectors hard wired to the fire alarm system installed in 15 of 79 resident sleeping rooms. The facility has a capacity of 140 and had a census of 86 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/29/14.</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 Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1. Based on observation and interview, the facility failed to ensure 1 of 2 battery</p> | K010046 | K046 NFPA 101 Life Safety Code Standard | 06/20/2014 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 05/21/2014 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>operated emergency lights was maintained in accordance with LSC 7.9. LSC 7.9.2.4 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect 120 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:20 p.m. to 3:10 p.m. on 05/21/14, the battery powered emergency light located in the Maintenance Mechanical Room failed to illuminate when its test button was pressed. The Maintenance Mechanical Room contained one of two emergency generator automatic transfer switch locations for the facility. The Maintenance Director disconnected the battery powered emergency light from the wall after the light failed to illuminate. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned battery operated emergency light failed to</p> | | <p>It is the practice of this facility to comply with K046 for emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>No residents were affected by this alleged finding as it relates to emergency lighting.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <ul style="list-style-type: none"> - Residents who reside in this facility have the potential to be affected by this alleged finding. - A new emergency light was installed on 5/28/14 to replace the unit that was identified during the observation on 5/21/14 in the TCU Mechanical Room. <p>The Maintenance Supervisor (MS) has checked emergency lighting in the center for proper functioning with no negative findings.</p> <p>The MS will round the building each week checking emergency lighting for proper functioning in</p> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/21/2014 |
|---|--|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | | | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | illuminate when its test button was pressed. 3.1-19(b) | | <p>accordance with 7.9.19.2.9.1.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>- MS will be educated on complying with this alleged deficient practice relating to emergency lighting.</p> <p>If the MS fails to comply with expectation of ensuring emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9.19.2.9.1, he will be educated and/or progressively disciplined as indicated.</p> <p><u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</u></p> <p>- Results of the monitoring will be reviewed for patterns/trends weekly by the Administrator/Designee. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved.</p> <p>Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make</p> | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/21/2014 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | | | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| K010052 SS=E | <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 record review, observation and interview; the facility failed to ensure 1 of 75 smoke detectors was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be</p> | K010052 | <p>recommendations monthly ongoing.</p> <p>- <u>By what date the systemic changes will be completed?</u></p> <p>- June 20, 2014</p> <p>K052 NFPA 101 Life Safety Code Standard</p> <p>It is the practice of this facility to comply with K052 with 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><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>No residents were affected by this alleged finding as it relates to a fire alarm system required for life safety is installed, tested, and</p> | 06/20/2014 | |

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/21/2014 | |
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | <p>maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect 10 residents, staff and visitors in the same smoke compartment as the lobby.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire & Security "Sensitivity and Detection Inspection Report" documentation dated</p> | | <p>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><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <p>- Residents who reside in this facility have the potential to be affected by this alleged finding.</p> <p>The smoke detectors identified in room 809 and room 811 was tested on 5-27-14. The smoke detectors passed inspection and the center received the report with the result of the sensitivity testing demonstrating that it was in fact within acceptable range.</p> <p>The MS checked the smoke detectors in the remaining center to ensure that they passed inspection and had documentation with the sensitivity range demonstrating compliance with NFPA 72, 7-3.2.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>- MS will be educated on</p> | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/21/2014 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | | | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| K010062 | <p>09/05/13 with the Maintenance Director during record review from 9:30 a.m. to 11:45 a.m. on 05/21/14, the photo smoke detector identified as "waiting area" had no sensitivity alarm point listed as the result of sensitivity testing. "To (too) high for sensitivity" was listed in the comments section of the report. Based on interview at the time of record review, the Maintenance Director stated no additional sensitivity testing documentation was available for review and acknowledged sensitivity testing documentation within the most recent two year period for the waiting area smoke detector was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 12:20 p.m. to 3:10 p.m. on 05/21/14, a smoke detector hard wired to the fire alarm system was observed in the lobby.</p> <p>3.1-19(b)</p> <p>NFPA 101</p> | | <p>compliance NFPA 72, 7-3.2 as it relates to ensuring that the "Sensitivity and Detection Inspection Report" has the proper documentation proving compliance with smoke detectors.</p> <p>If the MS fails to comply with NFPA 72, 7-3.2, he will be educated and/or progressively disciplined as indicated.</p> <p><u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</u></p> <p>- Results of future testing will be monitored and reviewed for non-compliance by the Administrator/Designee. Any non-compliance identified will be addressed with a Plan of Action to be reviewed by the Administrator/Designee until compliance is achieved.</p> <p>Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p> <p>- <u>By what date the systemic changes will be completed?</u></p> <p>- June 20, 2014</p> | | |

| | | | | | | | |
|---|---|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/21/2014 | |
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| SS=E | <p>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 observation and interview, the facility failed to replace 2 of over 100 sprinklers in the facility which had become corroded, had paint, lint or other foreign materials on them. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 37 residents, staff and visitors in the vicinity of the South Mechanical Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:20 p.m. to 3:10 p.m. on 05/21/14, the automatic sprinkler located behind the dryers in the Laundry was covered with lint and the automatic sprinkler located in the South Mechanical room had become green with corrosion.</p> | K010062 | <p>K062 NFPA 101 Life Safety Code Standard</p> <p>It is the practice of this facility to comply with K062 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.</p> <p><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>- No residents were affected by this alleged finding as it relates to requiring automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <p>- Residents who reside in this facility have the potential to be affected by this alleged finding.</p> <p>MS corrected the automatic</p> | 06/20/2014 | | | |

| | | | | | |
|---|---|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/21/2014 |
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | | | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned automatic sprinklers were either covered with lint or corroded. 3.1-19(b) | | <p>sprinkler located behind the dryers in the Laundry on 5/22/14 by removing the lint/debris.</p> <p>The automatic sprinkler located in the South Mechanical room was replaced on 6/2/14.</p> <p>MS reviewed the remaining automatic sprinklers throughout the center with appropriate corrected measures taken.</p> <p>Monitoring, utilizing an audit tool, of the automatic sprinklers in the center will continue weekly by the MS for four consecutive weeks. Afterwards, random monitoring will occur weekly ongoing.</p> <p>Any automatic sprinkler found to be in non-compliance with the standards and expectations of NFPA 25 will be addressed immediately.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>- MS will be educated on NFPA 25 with emphasis on automatic sprinkler being properly inspected, tested and maintained.</p> <p>If the MS fails to comply with these expectations, he will be educated and/or progressively disciplined as indicated.</p> | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 05/21/2014 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|--|----------------------|
| K010064 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 22 portable fire extinguishers had pressure gauge readings in the acceptable range. NFPA 10, Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires | K010064 | <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</u> - Results of the monitoring will be reviewed for patterns/trends weekly by Administrator/Designee. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing. <u>By what date the systemic changes will be completed?</u> - June 20, 2014 | 06/20/2014 |

| | | | | | | | |
|---|---|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/21/2014 | |
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | <p>the periodic monthly check shall ensure the pressure gauge reading is in the operable range. NFPA 10 at 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect two staff and visitors in the Activities Office.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:20 p.m. to 3:10 p.m. on 05/21/14, the pressure gauge on the portable fire extinguisher affixed to a hanger on the wall in the Activities Office showed the extinguisher was undercharged. The inspection tag on the portable fire extinguisher listed the most recent annual inspection was in December 2013 and the most recent monthly inspection was April 2014. Based on interview at the time of observation, the Maintenance Director acknowledged the Activities Office portable fire extinguisher pressure gauge indicated the fire extinguisher was undercharged.</p> <p>3.1-19(b)</p> | | <p>NFPA 10</p> <p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>- No residents were affected by this alleged finding as it relates to requiring 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><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <p>- Residents who reside in this facility have the potential to be affected by this alleged finding.</p> <p>The portable fire extinguisher in the Activities Office was changed out on 5/21/14 with one that had a pressure gauge reading in the operable range.</p> <p>Weekly, the MS will inspect each portable fire extinguisher to ensure that the pressure gauge is reading in the operable range.</p> <p>This monitoring, utilizing an audit tool will continue until four consecutive weeks of zero negative findings are achieved. Afterwards monthly monitoring</p> | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/21/2014 |
|---|--|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | | | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | | | <p>will take place ongoing.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>- MS will be educated on NFPA 10 with emphasis on ensuring that portable fire extinguishers have a pressure gauge reading in the operable range.</p> <p>Any portable fire extinguishers with readings of the pressure gauge not in the operable range will be addressed immediately. If MS fails to comply with these expectations will be educated and/or progressively disciplined as indicated.</p> <p><u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</u></p> <p>- Results of the monitoring will be reviewed for patterns/trends by Administrator/Designee. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved.</p> <p>Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make</p> | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 05/21/2014 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|--|----------------------|
| K020000 | <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: 05/21/14</p> <p>Facility Number: 000231 Provider Number: 155338 AIM Number: 100267900</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Manorcare Health Services - Prestwick 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. Building 0202, which consisted of the Therapy Care Unit (TCU) wing, was surveyed using Chapter 18, New Health</p> | K020000 | <p>recommendations quarterly ongoing.</p> <p>- <u>By what date the systemic changes will be completed?</u></p> <p>- June 20, 2014</p> <p>The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____ | X3) DATE SURVEY COMPLETED 05/21/2014 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| K020029 SS=E | <p>Care Occupancies.</p> <p>This one story facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building 0202, built in 2007, 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 and in all areas open to the corridor. The facility has battery operated smoke detectors installed in 64 of 79 resident sleeping rooms and has smoke detectors hard wired to the fire alarm system installed in 15 of 79 resident sleeping rooms. The facility has a capacity of 140 and had a census of 86 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</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 Hazardous areas are protected in</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____ | X3) DATE SURVEY COMPLETED 05/21/2014 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|--|----------------------|
| | <p>accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 15 doors serving hazardous areas such as fuel fired heater rooms were enclosed with a 3/4 hour fire rated door. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the TCU Mechanical Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:20 p.m. to 3:10 p.m. on 05/21/14, the TCU Mechanical Room has an inside storage room which contained a natural gas fired water heater and neither the corridor door to the TCU Mechanical Room or the door to the inside storage room had an affixed fire resistance rating label. Based on record review of facility blueprints and TCU construction documentation with the Maintenance Director at 2:30 p.m., the fire resistance rating of the aforementioned doors could not be determined. Based on interview at the time of observation and record review, the Maintenance Director acknowledged the fire resistance rating of</p> | K020029 | <p>K029 NFPA 101 Life Safety Code Standard</p> <p>It is the practice of this facility to comply with K029. Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a ¾ hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8 18.3.2.1.</p> <p><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>- No residents were affected by this alleged finding as it relates to hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a ¾ hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8 18.3.2.1.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be</u></p> | 06/20/2014 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____ | X3) DATE SURVEY COMPLETED 05/21/2014 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|--|----------------------|
| | <p>the aforementioned doors could not be determined.</p> <p>3.1-19(b)</p> | | <p><u>identified and what corrective action(s) will be taken?</u></p> <p>- Residents who reside in this facility have the potential to be affected by this alleged finding.</p> <p>MS checked other doors in the center to ensure that they had the correct fire-rated barrier. No doors were found to be in non-compliance. A new door was ordered on 6/5/2014 in order to comply with hazardous areas that are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a ¾ hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8 18.3.2.1.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>- MS was educated on hazardous areas that are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a ¾ hour fire-rated door, without windows (in accordance with 8.4).</p> <p>If the center should need to replace doors in the center, the fire-rated barrier will be reviewed with the Administrator to ensure it</p> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/21/2014 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | | | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | | | <p>meets the requirements with 8.4.</p> <p>Failure to comply with these expectations will result in education and/or progressively disciplined as indicated.</p> <p><u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</u></p> <p>- Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations quarterly ongoing.</p> <p><u>By what date the systemic changes will be completed?</u></p> <p>- June 20, 2014</p> <p>K046 NFPA 101 Life Safety Code Standard</p> <p>It is the practice of this facility to comply with K046 for emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>No residents were affected by this</p> | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____ | X3) DATE SURVEY COMPLETED 05/21/2014 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|--|----------------------|
| | | | <p>alleged finding as it relates to emergency lighting.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <ul style="list-style-type: none"> - Residents who reside in this facility have the potential to be affected by this alleged finding. - A new emergency light was installed on 5/28/14 to replace the unit that was identified during the observation on 5/21/14 in the TCU Mechanical Room. <p>The Maintenance Supervisor (MS) has checked emergency lighting in the center for proper functioning with no negative findings.</p> <p>The MS will round the building each week checking emergency lighting for proper functioning in accordance with 7.9.19.2.9.1.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <ul style="list-style-type: none"> - MS will be educated on complying with this alleged deficient practice relating to emergency lighting. <p>If the MS fails to comply with</p> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/21/2014 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | | | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| K020046 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1 Based on observation and interview, the | K020046 | <p>expectation of ensuring emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9.19.2.9.1, he will be educated and/or progressively disciplined as indicated.</p> <p><u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</u></p> <p>- Results of the monitoring will be reviewed for patterns/trends weekly by the Administrator/Designee. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved.</p> <p>Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p> <p><u>By what date the systemic changes will be completed?</u></p> <p>- June 20, 2014</p> | 06/20/2014 | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____ | X3) DATE SURVEY COMPLETED 05/21/2014 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|--|----------------------|
| | <p>facility failed to ensure 1 of 2 battery operated emergency lights was maintained in accordance with LSC 7.9. LSC 7.9.2.4 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:20 p.m. to 3:10 p.m. on 05/21/14, the battery powered emergency light located in the TCU Mechanical Room failed to illuminate when its test button was pressed five times. The TCU Mechanical Room contained one of two emergency generator automatic transfer switch locations for the facility. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned battery operated emergency light failed to illuminate when its test button was pressed five times.</p> <p>3.1-19(b)</p> | | <p>Code Standard</p> <p>It is the practice of this facility to comply with K046 for emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>No residents were affected by this alleged finding as it relates to emergency lighting.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <ul style="list-style-type: none"> - Residents who reside in this facility have the potential to be affected by this alleged finding. - A new emergency light was installed on 5/28/14 to replace the unit that was identified during the observation on 5/21/14 in the TCU Mechanical Room. <p>The Maintenance Supervisor (MS) has checked emergency lighting in the center for proper functioning with no negative findings.</p> <p>The MS will round the building each week checking emergency</p> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/21/2014 |
|---|--|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | | | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | | | <p>lighting for proper functioning in accordance with 7.9.19.2.9.1.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>- MS will be educated on complying with this alleged deficient practice relating to emergency lighting.</p> <p>If the MS fails to comply with expectation of ensuring emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9.19.2.9.1, he will be educated and/or progressively disciplined as indicated.</p> <p><u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</u></p> <p>- Results of the monitoring will be reviewed for patterns/trends weekly by the Administrator/Designee. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Administrator/Designee until compliance is achieved.</p> <p>Quality Assessment and Assurance Committee will review for ongoing compliance and</p> | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____ | X3) DATE SURVEY COMPLETED 05/21/2014 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|--|----------------------|
| K020052 SS=E | <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 record review, observation, and interview; the facility failed to document 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent</p> | K020052 | <p>accept and/or make recommendations monthly ongoing.</p> <p>- <u>By what date the systemic changes will be completed?</u></p> <p>- June 20, 2014</p> <p>K052 NFPA 101 Life Safety Code Standard</p> <p>It is the practice of this facility to comply with K052 with 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><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>No residents were affected by this alleged finding as it relates to a fire alarm system required for life</p> | 06/20/2014 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/21/2014 |
|---|---|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | | | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect 20 residents, staff and visitors in the TCU wing.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire & Security "Sensitivity and Detection Inspection Report" documentation dated</p> | | <p>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><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <p>- Residents who reside in this facility have the potential to be affected by this alleged finding.</p> <p>The smoke detectors identified in room 809 and room 811 was tested on 5-27-14. The smoke detectors passed inspection and the center received the report with the result of the sensitivity testing demonstrating that it was in fact within acceptable range.</p> <p>The MS checked the smoke detectors in the remaining center to ensure that they passed inspection and had documentation with the sensitivity range demonstrating compliance with NFPA 72, 7-3.2.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>-</p> | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/21/2014 |
|---|---|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | | | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>09/05/13 with the Maintenance Director during record review from 9:30 a.m. to 11:45 a.m. on 05/21/14, each of five duct detectors and the photo smoke detectors in Room 809 and Room 811 were not listed as being sensitivity tested. The aforementioned sensitivity test report stated no sensitivity range and no sensitivity alarm point for each of the five duct detectors and two smoke detectors. In the comments section of the report, it was stated "key switch" for four duct detectors in the MDS Office, the duct detector in the TCU Mechanical Room had no comment included and the photo smoke detectors in Room 809 and 811 stated "no access." Based on interview at the time of record review, the Maintenance Director stated additional sensitivity testing documentation was not available for review and acknowledged sensitivity testing documentation within the most recent two year period for the aforementioned initiating devices was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 12:20 p.m. to 3:10 p.m. on 05/21/14, five duct detectors and smoke detectors hard wired to the fire alarm system were observed installed in the TCU wing.</p> <p>3.1-19(b)</p> | | <p>MS will be educated on compliance NFPA 72, 7-3.2 as it relates to ensuring that the "Sensitivity and Detection Inspection Report" has the proper documentation proving compliance with smoke detectors.</p> <p>If the MS fails to comply with NFPA 72, 7-3.2, he will be educated and/or progressively disciplined as indicated.</p> <p><u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</u></p> <p>- Results of future testing will be monitored and reviewed for non-compliance by the Administrator/Designee. Any non-compliance identified will be addressed with a Plan of Action to be reviewed by the Administrator/Designee until compliance is achieved.</p> <p>Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.</p> <p>- <u>By what date the systemic changes will be completed?</u></p> <p>- June 20, 2014</p> | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/12/2014
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338 | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/21/2014 |
| NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK | | | STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | | | | | |