

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/25/2014
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NAME OF PROVIDER OR SUPPLIER  NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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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: 08/25/14</p> <p>Facility Number: 010758 Provider Number: 155662 AIM Number: 200229550</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Nursing Care at Hartsfield Village 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. The original one story building except a a therapy gym on the first floor and a six bed addition in rooms B209 to B214 on the second floor was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>The facility is a two story building with a one story section and a partial basement. The one story section is Type II (000)</p>	K010000	<p>Dear Mr. Booher, Enclosed is Nursing Care at Hartsfield Village's Plan of Correction and associated QAA Monitoring Tools for Survey Event ID RCYW21. Thank you for your attention to this matter. Please do not hesitate to contact me should you need additional information. I look forward to working with you. Respectfully submitted, Susan M. FinnAdministratorPhone: 219-934-0590 x102</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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	<p>construction and the two story building is of Type II (111) construction. Because the one story and two sections of the building are not separated by two hour rated construction, the building is considered one building of Type II (000) construction. The building is fully sprinklered with supervised smoke detectors on all levels including in corridors, in resident rooms, and in areas open to the corridor. The facility has the capacity for 112 and had a census of 111 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 08/26/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 doors serving hazardous areas such as a kitchen was held open only by a device arranged to automatically close the door or close the door upon activation of the fire alarm system. This deficient practice could affect at least 10 residents using the corridor outside the kitchen as well as an undetermined number of staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director at 12:00 p.m. on 08/25/14, the kitchen/dish room corridor door was held open by a device, a wooden wedge, which would not allow the door to close automatically upon</p>	K010021	<p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</b></p>	09/07/2014
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	<p>activation of the fire alarm system. Based on interview during the times of observation, the Maintenance Director acknowledged the door should not be propped open.</p> <p>3.1-19(b)</p>		<p><b>K021</b> Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility. The facility failed to ensure that one door serving hazardous areas such as a kitchen was held open only by a device arranged to automatically close the door or close the door upon activation of the fire alarm system.</p> <p><b>Corrective action taken for residents found to have been affected by the deficient practice:</b> At the time of survey, the kitchen/dish room door was propped open with a wooden wedge. The wedge was removed immediately. The kitchen/dish room door does have a functioning device in place to allow the door to close automatically. <b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All residents using the service corridor could potentially be affected. <b>To ensure that proper practices continue:</b> All dietary staff will be in-serviced regarding not using any device that would not allow the door to close automatically. All doors serving hazardous areas were checked to ensure a proper closing device is in place. The Maintenance Director/Designee will initiate a monitoring tool and</p>		

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K010027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing		conduct random audits 3x/weekly for 4 weeks to ensure that all doors serving hazardous areas remain in compliance with this plan of correction. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved at least 90% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 90% compliance has been achieved, the monitoring tools will continue for another 4 week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 90% compliance and has ensured the deficient practice will not recur. <b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed. Completion Date: September 7, 2014		

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	<p>or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 5 sets of second floor smoke barrier doors would close to form a smoke resistant barrier. This deficient practice could affect at least 10 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director at 11:20 a.m. on 08/25/14, when the north door in the second floor B wing set of smoke barrier doors was pulled from the hold open magnet, the door rubbed against the carpeting, moved only about an inch and would not close to form a smoke resistive barrier. Based on interview at the time of observation, the Maintenance Director acknowledged the door set did not close completely because the north door of the second floor B wing smoke barrier rubbed against the carpeting.</p> <p>3.1-19(b)</p>	K010027	<p>Nursing Care at Hartsfield Village</p> <p>503 Otis Bowen Drive</p> <p>Munster, Indiana 46321</p> <p><b>This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</b></p> <p>K027</p> <p>Door openings in smoke barriers have at least a 20-minute fire</p>	09/07/2014	

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			<p>protection rating; doors are self-closing or automatic closing. The facility failed to ensure that one set of second floor smoke barrier doors would close to form a smoke resistant barrier.</p> <p><b>Corrective action taken for residents found to have been affected by the deficient practice:</b></p> <p>The north door in the second floor B wing set of smoke barrier doors was repaired so it no longer rubs on the carpet. It now closes completely to form a smoke resistive barrier.</p> <p><b>Identification of other residents having the potential to be affected by the same deficient practice:</b></p> <p>All residents on the second floor could potentially be affected.</p> <p><b>To ensure that proper practices continue:</b></p> <p>All smoke barrier doors were checked to ensure they close completely to form a smoke resistant barrier.</p>	

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K010029	NFPA 101		<p>The Maintenance Director/Designee will initiate a monitoring tool and conduct random audits 3x/weekly for 4 weeks to ensure that all smoke barrier doors remain in compliance with this plan of correction. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved at least 90% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 90% compliance has been achieved, the monitoring tools will continue for another 4 week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 90% compliance and has ensured the deficient practice will not recur.</p> <p><b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b></p> <p>Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed.</p> <p>Completion Date: September 7, 2014</p>		

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SS=E	<p><b>LIFE SAFETY CODE STANDARD</b> 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> <p>Based on observation and interview, the facility failed to ensure 2 of 10 doors serving hazardous areas such as a kitchen or combustible storage room over 50 square feet in size closed and latched to prevent the passage of smoke. This deficient practice could affect at least 10 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director from 12:00 p.m. to 12:30 p.m. on 08/25/14, the following was noted:</p> <p>a. The Housekeeping Director's office door was not provided with a self closing device. This room exceeded 50 square feet. Combustible storage in the Housekeeping Director's office included a large quantity of cardboard boxes, paper goods and ten 1.2 liter containers of alcohol based hand sanitizer.</p>	K010029	<p>Nursing Care at Hartsfield Village</p> <p>503 Otis Bowen Drive</p> <p>Munster, Indiana 46321</p> <p><b>This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is</b></p>	09/07/2014	

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	<p>b. The kitchen service hall door was provided with a self closer but did not latch into the frame. Based on interview at the time of observation, the Maintenance Director acknowledged air pressure was keeping the kitchen service hall door from closing completely so the door would latch into the frame.</p> <p>3.1-19(b)</p>		<p><b>required by the provision of federal and state law.</b></p> <p><b>K029</b></p> <p>The facility failed to ensure two doors serving hazardous areas such as a kitchen or combustible storage room over 50 square feet in size closed and latched to prevent the passage of smoke.</p> <p><b>Corrective action taken for residents found to have been affected by the deficient practice:</b></p> <p>A self-closing device was installed on the housekeeping director's office door.</p> <p>The kitchen service hall door was repaired and adjusted to close and latch properly into the frame.</p> <p><b>Identification of other residents having the potential to be affected by the same deficient practice:</b></p> <p>All residents using the service corridor could potentially be affected.</p>	

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			<p><b>To ensure that proper practices continue:</b></p> <p>All hazardous areas over 50 square feet in size were checked to ensure that doors close and latch properly.</p> <p>The Maintenance Director/Designee will initiate a monitoring tool and conduct random audits 3x/weekly for 4 weeks to ensure that all doors serving hazardous areas remain in compliance with this plan of correction. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved at least 90% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 90% compliance has been achieved, the monitoring tools will continue for another 4 week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 90% compliance and has ensured the deficient practice will not recur.</p> <p><b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b></p> <p>Identified concerns shall be reviewed by the facility's QAA</p>		

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K010051 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 manual fire alarm boxes within the Special Care unit were 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</p>	K010051	<p>Committee. Recommendations for further corrective action will be discussed and implemented as needed.</p> <p>Completion Date: September 7, 2014</p> <p>Nursing Care at Hartsfield Village</p> <p>503 Otis Bowen Drive</p> <p>Munster, Indiana 46321</p> <p><b>This plan of correction represents the center's allegation of</b></p>	09/07/2014

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	<p>from the area. This deficient practice could affect at least 10 residents, staff and visitors on the special care unit.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director at 12:35 p.m. on 08/25/14, the manual fire alarm pull station in the first floor Special Care unit south exterior exit vestibule was not readily accessible in that the pull station was located beyond the magnetically locked exit door and would require the use of a code to access the pull station. Based on interview at the time of observation, the Maintenance Director acknowledged a person would have to enter the code to open the door to access the pull station.</p> <p>3.1-19(b)</p>		<p><b>compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</b></p> <p><b>K051</b></p> <p>A fire alarm system with approved components, devices or equipment is installed to provide effective warning of fire in any part of the building. The facility failed to ensure one manual fire alarm box within the Special Care Unit was readily accessible.</p> <p><b>Corrective action taken for residents found to have been affected by the deficient practice:</b></p> <p>The manual fire alarm box located at the south exit of the Special Care</p>		

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			<p>Unit was located between the doors of a vestibule. The interior door has a magnetically locking device. The manual fire alarm box was moved to the interior door. The magnetic lock is designed to release upon the activation of the fire alarm system.</p> <p><b>Identification of other residents having the potential to be affected by the same deficient practice:</b></p> <p>All residents in the Special Care Unit have the potential to be affected.</p> <p><b>To ensure that proper practices continue:</b></p> <p>All manual fire alarm boxes were checked to ensure they are readily accessible.</p> <p>The manual fire alarm box at the south exit of the Special Care Unit has been relocated permanently to the interior door. The deficient practice has been corrected.</p> <p><b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  08/25/2014
NAME OF PROVIDER OR SUPPLIER  NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
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K010052 SS=C	<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 and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 7-3.2 requires testing be in accordance with Table 7-32. Table 7-3.2.15.h requires smoke detectors be function tested annually. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on review of the "Fire Alarm Inspection Report" dated 07/17/14 with the Maintenance Director on 08/25/14 at 10:45 a.m., there were 4 of 172 smoke detectors that were not function tested or</p>	K010052	<p>All Life Safety Code identified deficiencies will be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed.</p> <p>Completion Date: September 7, 2014</p> <p>Nursing Care at Hartsfield Village</p> <p>503 Otis Bowen Drive</p> <p>Munster, Indiana 46321</p> <p><b>This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or</b></p>	09/07/2014	

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	<p>sensitivity tested due to lack of access. The report indicated, "The devices in the elevator pits and shafts were not tested during the inspection due to no elevator tech onsite." Based on interview during the time of reord review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p><b>agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</b></p> <p><b>K52</b></p> <p>A fire alarm system required for life safety is installed, tested and maintained. The facility failed to maintain one fire alarm system in accordance with NFPA 72. 4 of 172 smoke detectors were not function tested during the July 2014 inspection due to lack of access.</p> <p><b>Corrective action taken for residents found to have been affected by the deficient practice:</b></p> <p>The four smoke detectors located in the elevator pits and shafts were inspected. All four devices were tested and are functioning appropriately.</p> <p><b>Identification of other residents having the potential to be affected by the same deficient practice:</b></p>				

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NAME OF PROVIDER OR SUPPLIER  NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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K010064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with		<p>All residents in the facility could potentially be affected.</p> <p><b>To ensure that proper practices continue:</b></p> <p>Reviewed all smoke detector inspection reports to ensure compliance with annual inspection. The facility is currently in compliance with inspections and is scheduled for the next annual inspection in July 2015.</p> <p><b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b></p> <p>All Life Safety Code identified deficiencies will be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed.</p> <p><b>Completion Date:</b> September 7, 2014</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155662		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  08/25/2014	
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	<p>9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 30 portable fire extinguishers was maintained in accordance with NFPA 10, 1998 Edition, the Standard for Portable Fire Extinguishers. NFPA 10, Section 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. NFPA 10, Section 4-4.4.2 requires each extinguisher that has undergone maintenance that includes internal examination or that has been recharged shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch. This deficient practice could any of the kitchen staff.</p>	K010064	<p>Nursing Care at Hartsfield Village</p> <p>503 Otis Bowen Drive</p> <p>Munster, Indiana 46321</p> <p><b>This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</b></p> <p><b>K064</b></p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with NFPA 10. The facility failed to ensure 1 portable fire extinguisher was</p>	09/07/2014			

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	<p>Findings include:</p> <p>Based on observation on 08/25/14 at 12:15 p.m. with the Maintenance Director, the annual maintenance tag attached to the portable K Class fire extinguisher located in the kitchen indicated the last annual maintenance procedure for the extinguisher was performed in July 2013 and had the word "Test" handwritten on the tag. Additionally, the K Class fire extinguisher had a six year maintenance tag affixed to it dated 7/2013 but did not have a "Verification of Service" collar. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>maintained and issued a "verification of service" collar.</p> <p><b>Corrective action taken for residents found to have been affected by the deficient practice:</b></p> <p>The K Class fire extinguisher located in the kitchen was replaced with a tested unit with the verification of service collar in place.</p> <p><b>Identification of other residents having the potential to be affected by the same deficient practice:</b></p> <p>All persons in the kitchen could potentially be affected.</p> <p><b>To ensure that proper practices continue:</b></p> <p>All portable fire extinguishers in the facility were checked to ensure compliance with maintenance standards.</p> <p>The Maintenance Director/Designee will initiate a monitoring tool and conduct random audits 3x/weekly for 4 weeks to ensure that all portable fire extinguishers remain in</p>		

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K010072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or		<p>compliance with this plan of correction. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved at least 90% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 90% compliance has been achieved, the monitoring tools will continue for another 4 week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 90% compliance and has ensured the deficient practice will not recur.</p> <p><b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b></p> <p>Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed.</p> <p>Completion Date: September 7, 2014</p>		

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	<p>impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of impediments to full instant use in the case of fire or other emergency for 1 of 6 exits. This deficient practice could affect at least 10 residents as well as staff and visitors on the Special Care unit.</p> <p>Findings include:</p> <p>Based on observation on 08/25/14 with the Maintenance Director at 12:55 p.m., the first floor Special Care unit south exterior exit door required excessive force to open. Based on interview at the time of observation, the Maintenance Director acknowledged the door was difficult to open and indicated the door was rusty at the bottom of the door.</p> <p>3.1-19(b)</p>	K010072	<p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</b></p> <p><b>K072</b> Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. The facility failed to ensure that the means of egress was continuously free as evidenced by the south exterior exit door on the Special Care Unit required excessive force to open.</p> <p><b>Corrective action taken for residents found to have been</b></p>	09/07/2014	

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			<p><b>affected by the deficient practice:</b> The south exterior exit door of the Special Care Unit was cleaned and repaired to ensure that it opens freely and without use of excessive force.</p> <p><b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All residents on the Special Care Unit have the potential to be affected. <b>To ensure that proper practices continue:</b> All exit doors were checked to ensure they are free of obstructions and are functioning properly. The Maintenance Director/Designee will initiate a monitoring tool and conduct random audits 3x/weekly for 4 weeks to ensure that all exit doors remain in compliance with this plan of correction. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved at least 90% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 90% compliance has been achieved, the monitoring tools will continue for another 4 week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 90% compliance and has ensured the deficient practice will not recur.</p> <p><b>Quality Assurance Plan to monitor compliance with this</b></p>	

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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: 08/25/14</p> <p>Facility Number: 010758 Provider Number: 0155662 AIM Number: 200229550</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Nursing Care At Hartsfield Village 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. The new addition, consisting of a six bed addition in rooms B209 to B214 on the second floor and a therapy gym on</p>	K020000	<p><b>Plan of Correction:</b> Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed. Completion Date: September 7, 2014</p> <p>Dear Mr. Booher, Enclosed is Nursing Care at Hartsfield Village's Plan of Correction and associated QAA Monitoring Tools for Survey Event ID RCYW21. Thank you for your attention to this matter. Please do not hesitate to contact me should you need additional information. I look forward to working with you. Respectfully submitted, Susan M. FinnAdministratorPhone: 219-934-0590 x102</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED  08/25/2014
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	<p>the first floor was surveyed with Chapter 18, New Health Care Occupancies</p> <p>This two story addition was determined to be of Type II (111) construction and fully sprinklered. Because the one story and two sections of the building are not separated by two hour rated construction, the building is considered one building of Type II (000) construction. The facility has a fire alarm system with automatic smoke detection in the corridors, in resident sleeping rooms and in areas not separated from the corridor. The facility has a capacity of 112 beds and had a census of 111 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>			

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K020052 SS=C	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b> 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 and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 7-3.2 requires testing be in accordance with Table 7-32. Table 7-3.2.15.h requires smoke detectors be function tested annually. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on review of the "Fire Alarm Inspection Report" dated 07/17/14 with the Maintenance Director on 08/25/14 at 10:45 a.m., there were 4 of 172 smoke detectors that were not function tested or sensitivity tested due to lack of access. The report indicated, "The devices in the elevator pits and shafts were not tested during the inspection due to no elevator tech onsite." Based on interview during the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p>	K020052	<p>Nursing Care at Hartsfield Village</p> <p>503 Otis Bowen Drive</p> <p>Munster, Indiana 46321</p> <p><b>This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</b></p>	09/07/2014			

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	3.1-19(b)		<p><b>K52</b></p> <p>A fire alarm system required for life safety is installed, tested and maintained. The facility failed to maintain one fire alarm system in accordance with NFPA 72. 4 of 172 smoke detectors were not function tested during the July 2014 inspection due to lack of access.</p> <p><b>Corrective action taken for residents found to have been affected by the deficient practice:</b></p> <p>The four smoke detectors located in the elevator pits and shafts were inspected. All four devices were tested and are functioning appropriately.</p> <p><b>Identification of other residents having the potential to be affected by the same deficient practice:</b></p> <p>All residents in the facility could potentially be affected.</p> <p><b>To ensure that proper practices continue:</b></p> <p>Reviewed all smoke detector inspection reports to ensure</p>		

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			<p>compliance with annual inspection. The facility is currently in compliance with inspections and is scheduled for the next annual inspection in July 2015.</p> <p><b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b></p> <p>All Life Safety Code identified deficiencies will be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed.</p> <p><b>Completion Date:</b> September 7, 2014</p>	