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 08/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES - PRESTWICK	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
K 0000 Bldg. 01	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). Survey Date: 08/17/16 Facility Number: 000231 Provider Number: 155338 AIM Number: 100267900 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. 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 Type V (111) construction and was fully sprinklered. The facility has a fire alarm	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155338		08/17/2016

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MANORCARE HEALTH SERVICES - PRESTWICK	445 S CR 525 E AVON, IN 46123

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	system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in 63 of 78 resident sleeping rooms and has smoke detectors hard wired to the fire alarm system installed in 15 of 78 resident sleeping rooms. The facility has a capacity of 140 and had a census of 74 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/22/16 - DA			
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 Based on observation and interview, the facility failed to ensure 3 of 20 hazardous areas such as combustible storage rooms greater than 50 square feet in size were	K 0029	Preparation and/or execution of this plan of correctiondoes not constitute admission or agreement by the provider of the truth of thefacts alleged or	09/16/2016

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 08/17/2016
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
	separated from other spaces by self closing doors. Doors to hazardous areas are self-closing or close automatically upon activation of the fire alarm system. This deficient practice could affect over 50 residents, staff and visitors. Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:15 a.m. to 1:20 p.m. on 08/17/16, the corridor door to Room 112, Room 113 and Room 701 were each not equipped with a self-closing device. Each of the three aforementioned rooms measured greater than 144 square feet in size and were used to store combustible boxes and supplies. Based on interview at the time of the observations, the Environmental Director stated the aforementioned three rooms were resident rooms which are now being used temporarily as storage rooms and acknowledged the corridor doors to the aforementioned three hazardous rooms were not separated from other spaces by self closing doors. 3.1-19(b)		conclusions set forth in the statement of deficiencies. Theplan of correction is prepared and/or executed solely because it is required bythe provisions of federal and state law. It is the practice of this facility to ensure K 029 It is the practice of this facility to ensure that allstorage areas with combustible storage greater than 50 square feet in size haveself-closing doors. Consistent with this practice the following actions havebeen taken: I. Self- closing hinges were applied to identified doorsin rooms #112, #113, and #701. II. An audit ofall doors that could have been affected by the deficient practice was conducted.No other doors were identified to have been affected by the deficient practice. III. Staff have beenin-serviced regarding compliance with NFPA Life Safety Code Standard related tothe self-closing door requirements on areas with combustible storage greaterthan 50 square feet in size. The MaintenanceDirector or	

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			designee(s) will utilize a QAPI tool developed to ensurecompliance. This QAPI tool will becompleted by the Maintenance Director or designee daily, during scheduled daysof work, times 30 days, then weekly times 1 month, and finally monthly times 6months or until 100% compliance is reached. IV. The MaintenanceDirector or designee(s) will monitor the above corrective actions for ongoingcompliance by completing a collective review of all audits monthly. The MaintenanceDirector or designee will then report findings to the QAPI Team monthly times 6months to determine need for continued monitoring thereafter until a thresholdof 100% compliance is reached	
K 0038 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 13 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states	K 0038	K 038 It is the practice of this facility to ensure that doorswithin a required means of egress shall not be equipped with a latch or lockthat requires the use of a tool or key from the egress side. Consistent with this practice the following actions havebeen taken:	09/16/2016

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

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	door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 20 residents, staff and visitors if needing to exit the facility from the South Dining Room courtyard exit to the public way. Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:15 a.m. to 1:20 p.m. on 08/17/16, the South Dining Room exit door to the outdoor courtyard was marked as a facility exit and was magnetically locked and could be opened by entering a four digit code. The courtyard exit door to the public way was equipped with a magnetic holding device which will only release with activation of the fire alarm system. Based on interview at the time of the observations, the Environmental Director stated not all residents who have a clinical diagnosis to be in a secure building have access to the courtyard and acknowledged the courtyard exit door to the public way will only release with activation of the fire		I. The mag lock identifiedwas disconnected on the door identified in the court yard area and a latch wasinstalled on the inside of the gate. II. An audit of all similar egresses that could have beenaffected by the deficient practice was conducted. No other egresses wereidentified to have been affected by the deficient practice. III. Staffhas been in-serviced regarding compliance with NFPA Life Safety Code Standardrelated to the required means of egress not being equipped with a latch or lockthat requires the use of a tool or key from the egress side. The MaintenanceDirector or designee(s) will utilize a QAPI tool developed to ensurecompliance. This QAPI tool will becompleted by the Maintenance Director or designee daily, during scheduled daysof work, times 30 days, then weekly times 1 month, and finally monthly times 6months or until 100% compliance is reached. IV. The Maintenance Director or designee(s) will monitorthe above corrective actions for ongoing compliance by completing a collectivereview of all audits monthly. The Maintenance Director or designee will thenreport findings to the QAPI Team monthly times 6 months to determine need forcontinued monitoring thereafter until a threshold of 100% compliance is	

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	alarm system. 3.1-19(b)		reached.	
K 0064 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 Based on observation and interview, the facility failed to document inspection of 2 of 22 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect 58 residents, staff and visitors in the vicinity of the 300 Hall.	K 0064	It is the practice of this facility to ensure that inspectionsare documented on all portable fire extinguishers monthly. Consistent with this practice the following actions havebeen taken: I. The 2 portable fire extinguishers were inspected andthe inspections were documented. II. An auditof all fire extinguishers that could have been affected by the deficient practicewas conducted. All other fire extinguisher inspections were documented timely. III. Staffhas been in-serviced regarding compliance with NFPA Life Safety Code Standardrelated to the required inspection and documentation monthly on all portablefire extinguishers. The Maintenance Director or designee(s) will utilize a QAPItool	09/16/2016

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 08/17/2016

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	Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:15 a.m. to 1:20 p.m. on 08/17/16, the portable fire extinguisher in the corridor by Room 307 and in the Activities Office each had an inspection tag affixed to the extinguisher which indicated an annual inspection was conducted in November 2015. However, a monthly inspection was not documented for the eight month period of December 2015 through July 2016 for the fire extinguisher by Room 307 and was only documented for January 2016 for the Activities Office fire extinguisher. Based on interview at the time of the observations, the Environmental Director stated no other monthly fire extinguisher inspection documentation was available for review and acknowledged a monthly inspection for the aforementioned portable fire extinguishers. 3.1-19(b)		developed to ensure compliance. This QAPI tool will be completed by the Maintenance Director or designeedaily, during scheduled days of work, times 30 days, then weekly times 1 month,and finally monthly times 6 months or until 100% compliance is reached. IV. TheMaintenance Director or designee(s) will monitor the above corrective actionsfor ongoing compliance by completing a collective review of all audits monthly.The Maintenance Director or designee will then report findings to the QAPI Teammonthly times 6 months to determine need for continued monitoring thereafteruntil a threshold of 100% compliance is reached.	
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
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	9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.6 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 1999 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 in. (2.3 m) above the floor. NFPA 99, Section 7-5.2.2.1 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 58	K 0147	It is the practice of this facility to ensure that all extensioncords including power strips are not used as a substitute for fixed wiring. Consistent with this practice the following actions havebeen taken: I. The power strip was removed from room #304. II. An audit of the center was conducted to identify anyother areas that could have been affected by the deficient practice wasconducted. No other power strips were identified. III. Staff has been in-serviced regarding compliance withNFPA Life Safety Code Standard related to extension cords including powerstrips not being used as a substitute for fixed wiring. The Maintenance Director or designee(s) will utilize aQAPI tool developed to ensure compliance. This QAPI tool will be completed by the Maintenance Director or designeedaily, during scheduled days of work, times 30 days, then weekly times 1 month,and finally monthly times 6 months or until 100% compliance is reached. IV. The Maintenance Director or designee(s) will monitorthe above corrective actions for ongoing compliance by completing a	09/16/2016

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 08/17/2016
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	residents, staff and visitors in the vicinity of Room 304. Findings include: Based on observation with the Environmental Director during a tour of the facility from 11:15 a.m. to 1:20 p.m. on 08/17/16, an intravenous pump and a nebulizer were plugged into a power strip on the floor underneath the resident bed nearest the window in Room 304. Based on interview at the time of the observations, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring in the patient care vicinity in Room 304. 3.1-19(b) fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition		collectivereview of all audits monthly. The Maintenance Director or designee will thenreport findings to the QAPI Team monthly times 6 months to determine need forcontinued monitoring thereafter until a threshold of 100% compliance isreached.	

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	to prevent its operation. This deficient practice could affect 58 residents, staff and visitors in the vicinity of the 300 Hall. Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:15 a.m. to 1:20 p.m. on 08/17/16, the portable fire extinguisher in the corridor by Room 307 and in the Activities Office each had an inspection tag affixed to the extinguisher which indicated an annual inspection was conducted in November 2015. However, a monthly inspection was not documented for the eight month period of December 2015 through July 2016 for the fire extinguisher by Room 307 and was only documented for January 2016 for the Activities Office fire extinguisher. Based on interview at the time of the observations, the Environmental Director stated no other monthly fire extinguisher inspection documentation was available for review and acknowledged a monthly inspection for the aforementioned portable fire extinguishers. 3.1-19(b)			

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K 0000 Bldg. 02	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). Survey Date: 08/17/16 Facility Number: 000231 Provider Number: 155338 AIM Number: 100267900 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 Care Occupancies. This one story facility was surveyed as two separate buildings due to the construction dates of two sections of the	K 0000		

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	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 63 of 78 resident sleeping rooms and has smoke detectors hard wired to the fire alarm system installed in 15 of 78 resident sleeping rooms. The facility has a capacity of 140 and had a census of 74 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/22/16 - DA			